CMISM PATIENT INFORMATION HERE

FAMILY HEALTH CENTERS OF SAN DIEGO

QR CODE HERE

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

MRN: _____	CHECK IF APPLICABLE:
Patient name: _____	☐ Stat request
Date of birth: _____ Phone number: _____	☐ Processed/completed at clinic

AUTHORIZATION REQUEST

I authorize Family Health Centers of San Diego (FHCSD) to:

(CHECK ONE)
☐ Release records to
☐ Request records from

Name of person/facility: _____ Phone number: _____
Address/city/state/ZIP: _____
Treatment dates of service requested from: _____ to: _____

TYPE OF INFORMATION TO BE RELEASED

(CHECK ALL THAT APPLY)

☐ All medical records (immunizations, office/procedure notes, operative notes, lab & radiology results)
☐ Radiology report only ☐ Labs only
☐ Other records (please specify): _____

SENSITIVE INFORMATION

I specifically authorize the release of:

☐ Mental health treatment records
☐ SUD & alcohol treatment records
Meets 42 C.F.R. Part 2 requirements
☐ HIV labs & treatment notes

DELIVERY METHOD FOR PATIENT RELEASE ONLY

(CHECK ONE) ☐ Patient portal ☐ U.S. mail ☐ Encrypted/secure email ☐ Other: _____

USE OF INFORMATION

The recipient identified above is permitted to disclose my personal health information (PHI) for:

(CHECK ONE) ☐ Personal ☐ Legal ☐ Continuation of care (COC) ☐ Transition of care (TOC)

AUTHORIZATION

By signing below, I acknowledge I have read and understand pages 1 and 2 of this authorization.

Printed name: _____

Signature: _____ Date: _____

Adolescent patient signature if requesting records requiring special authorization:

_____ Date: _____

Indicate relationship if not the patient:

☐ Parent/legal guardian ☐ DPOA ☐ Other: _____

STAFF USE ONLY

WITNESS:	BADGE NUMBER/FACILITY:	DATE:
_____	_____	_____

Please carefully read the reverse side of this form before completing. All sections of this authorization must be filled out before FHCSD is permitted to provide or disclose your protected health information.

Explanation

This form authorizes Family Health Centers of San Diego (FHCSD) to disclose an individual's health information as specified. Unless specifically requested, this does not include records explicitly related to HIV/AIDS, mental health or substance use treatment. However, general medical notes may refer to these conditions if relevant to the individual's care. The released information may be used for coordination of care/treatment, insurance/payment, legal matters or personal review. Once disclosed, recipients of the information may not be legally required to protect it under privacy laws.

Authorization for release of medical records

By signing this release, the patient authorizes the disclosure of medical records, which may include sensitive information discussed during medical visits, such as alcohol use, drug use, HIV/AIDS-related illnesses and/or mental health conditions.

Specialty treatment records

This authorization does not automatically include the release of records related to specialty treatments for HIV/AIDS-related conditions, mental health or 42 C.F.R. Part 2 records for drug/alcohol use. To release such records, the corresponding boxes on page 1 of this form must be marked. I understand that my substance use disorder records are protected under the federal regulations governing confidentiality and substance use disorder patient records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts. 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Minors' rights

Under California law, patients ages 12–17 have the right to consent to certain treatment or services. In those cases, the patient must sign this form to authorize the release of those requested records.

Right to revoke authorization

This authorization may be revoked at any time, except to the extent that actions have already been taken based on it. To revoke authorization, a signed, written notice must be submitted to the Health Information Management Department or any FHCSD location.

Voluntary authorization

Signing this authorization is voluntary. Choosing to sign or not sign will not affect the ability to receive treatment, payment, enrollment or eligibility for benefits.

Restrictions on redisclosure

Under California law, any recipient of information regarding HIV/AIDS, mental health or drug/alcohol use is prohibited from redisclosing this information without written consent, unless specifically required or permitted by law. 42 C.F.R. Part 2 prohibits unauthorized use or disclosure of these records.

Federal privacy protections

If the recipient of the information is not a health plan or health care provider, the released information may no longer be protected under federal privacy regulations.

Right to copy

A copy of this authorization form may be requested.

Expiration

This authorization will expire six (6) months from the date it is signed. A photocopy or electronic copy is as valid as the original.

Electronic signatures

Electronic signatures on this form are governed by the federal ESIGN Act of 2000 and California Government Code Section 16.5. An electronic signature is equivalent to a handwritten signature. The signature provided includes the date and time of signing, and the signer's identity has been authenticated. In accordance with the federal ESIGN Act, no contract, signature or record shall be denied legal effect solely because it is in electronic form.

Return instructions

Completed forms should be returned to FHCSD via mail or fax using the contact information below:

Address:
823 Gateway Center Way
San Diego CA 92102

Fax: (619) 269-0132
Phone: (619) 515-2368

FAMILY HEALTH CENTERS OF SAN DIEGO