Sonoma County Indian Health Project, Inc.
144 Stony Point, Santa Rosa, CA 95401
Main Telephone (707) 521-4545
Medical/HIM 521-4500/Fax 544-4626 Dental 521-4600/Fax 521-4620
Behavioral Health 521-4550/Fax 544-1092

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____

Phone: _____ Date of Birth: _____

Address, City, State and Zip: _____

WHAT RECORDS DO YOU WANT TO RELEASE?

Records requested: Behavioral Health Dental Medical Pharmacy Billing

A health summary

Only the records from (date): _____ to (date): _____

Only records from a specific type of care or condition: _____

My complete health records

DO YOU WANT YOUR RECORDS TO INCLUDE INFORMATION ABOUT THESE CONDITIONS?

Please check	Initial		Please check	Initial	
		HIV Test Results			Alcohol/Drug Abuse Treatment/Referral
		Mental Health Treatment			
		Psychotherapy Notes **ONLY**. By checking this, I waive any psychotherapist-patient privilege.			

REASON FOR RELEASE?

Further Medical Care Insurance Personal Use Transfer care

Attorney School Disability Research

Other (Specify): _____

☐ **Release records TO Sonoma County Indian Health Project, Inc.**

RELEASE INFORMATION FROM THIS DOCTOR/FACILITY

Name: _____

Address: _____

City/State/Zip: _____

Telephone: _____ **Fax :** _____

MRN:_____

☐ ***Release records FROM Sonoma County Indian Health Project, Inc.***

RELEASE INFORMATION TO THIS DOCTOR/FACILITY

Name: _____

Address: _____

City/State/Zip: _____

Telephone: _____ ***Fax :*** _____

EXPIRATION

Authorization expires (indicate date, event or condition):_____

**If I fail to specify expiration date, event or condition, this authorization will expire six months from the date of signing.*

1. I have the right to receive a copy of this Authorization.
2. I understand that signing this form is voluntary and if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Sonoma County Indian Health Project, Inc. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the HIM department. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.
3. Information disclosed pursuant to this Authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However California law prohibits the person receiving my health care information from making further disclosure of it unless another Authorization of such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law (Subject to the Lanterman-Petris-Short Act and/or Alcohol and Drug Abuse Regulations).
4. I may inspect/obtain a copy of the health information that I am being asked to use or disclose.

Signature of patient or legal representative:

Signature:_____ Date:_____

Print Name:_____ Time:_____

*If signed by someone other than the patient, please **PRINT** the following information and state your legal relationship to the patient:*

Name:_____Relationship to Patient:_____

Witness:_____ Date:_____

Patient Name:_____**DOB:**_____**MRN:**_____