Sonoma County Indian Health Project, Inc.
144 Stony Point Road, Santa Rosa, CA 95401
Phone: 707-521-4545 • Fax: 707-544-4626

Authorization for Release of Protected Health Information

NOTE: This authorization is not valid if not filled out completely.

Patient Information

Patient Legal Name:_____
Date of Birth:_____ Phone:_____
Address:_____
City:_____ State:_____ Zip:_____

Release To/Request From

I authorize Sonoma County Indian Health Project, Inc. to:

☐ Release Information **TO** Person/Entity Listed Below:
☐ Request Information **FROM** Person/Entity Listed Below:
(Select One)

Person/Entity:_____
Address:_____
City, State, Zip:_____
Phone:_____
Fax:_____

Purpose for Release

For the Following:
(Select One)

☐ Personal
☐ Continuing Care
☐ Insurance
☐ Legal
☐ Other (Specify):

_____
_____

Delivery Preference

☐ Physical Pick-Up ☐ Fax ☐ Mail

Information to Release

Dates of Service or Date Range:_____

☐ Office Visit/Consult Note(s):_____
☐ Immunization Report
☐ Medication List
☐ Lab Results:_____
☐ Imaging/Procedure Report(s):_____
☐ Dental Records
☐ Pharmacy Records
☐ Billing Records
☐ Other (Please Specify):_____

Sensitive information will **NOT** be released unless specifically authorized below.

☐ HIV/AIDS ☐ Psychiatry
☐ Sexually Transmitted Infections ☐ Substance Use Disorder
☐ Psychotherapy **ONLY** (By checking this, I waive any psychotherapist-patient privilege)

Rights and Acknowledgements

By signing this form, I understand that:

1. I have a right to receive a copy of this authorization.
2. Signing this form is voluntary. If I do not sign, it will not affect my treatment at Sonoma County Indian Health Project, Inc.
3. I may revoke this authorization at any time, provide that I do so in writing and submit to:
   Sonoma County Indian Health Project, Inc.
   Health Information Management
   144 Stony Point Rd.
   Santa Rosa, CA 95401
4. The revocation will be effective immediately upon receipt and will not have any effect on any actions taken prior to receiving the revocation.
5. Health information used and disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal confidentiality regulations (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is required or permitted by law.

Expiration

This authorization expires (indicate date, event, or condition):_____

_____

If no date, event, or condition is specified this authorization will expire six months from the date of signing.

Signature

Print Name:_____

(Patient or Legal Representative)

Signature:_____ Date:_____

<u>If signed by someone other than patient, please complete the fields below.</u>

Relationship to Patient:_____

NOTE: If legal representative in any capacity please attach documents if not already filed with Sonoma County Indian Health Project, Inc.

Patient Legal Name:_____ Date of Birth:_____