OPEN DOOR COMMUNITY HEALTH CENTERS

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Note: Fees may apply to certain requests

Name of Patient:_____ Birth date:____/____/____

Contact Phone Number: (____)_____

The Person named above authorizes the following information to be requested or released by representatives of Open Door Community Health Centers.

I hereby authorize:

_____
Name of Person or Facility

_____
Address

_____
City State ZIP

(____)_____ (____)_____
Phone Fax

❑send health records to:
and / or
❑discuss information with:

_____
Name of Person or Facility to Receive Information

_____
Address

_____
City State ZIP

(____)_____ (____)_____
Phone Fax

SPECIFY RECORDS

Check the box and initial to specify which type of information is to be released.

a. ❑ All health information pertaining to my medical history, physical condition and treatment _____(initial); **OR**
❑ Only the following records or types of health information (specify & include dates)
_____/_____ (initial)

b. I specifically authorize release of the following information (initial as appropriate):
_____ Mental health treatment information
_____ HIV test results
_____ Alcohol/drug treatment information

c. The recipient may use the health information authorized on this form for the following purpose:
❑ Coordination of Care ❑ Other_____

DURATION:
This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____/_____/20___.
DATE

TO CANCEL THIS AUTHORIZATION:
You or your representative can cancel this authorization upon written request. If you cancel this authorization, it will not affect information disclosed before the receipt of written request.

MY RIGHTS

- You have the right to inspect the information you are authorizing to be released. This and other specific rights regarding the handling of your health information is outlined in the Open Door Community Health Centers' Notice of Privacy Practices.
- The information you are authorizing to be released could be re-released or disclosed by the recipient. Such additional disclosures or releases may not be prohibited by law. Open Door Community Health Centers is not responsible for the actions of others who may be provided with information released as a result of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your health care provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibility for benefits.
- You have the right to receive a copy of this authorization.

SIGNATURE

Print name:_____

Signature: _____ Date: ____/____/20___
(Patient/Legal Representative)

If signed by other than patient, indicate relationship:_____

FEE

There may be a fee associated with the copying of your records: If for personal use, you are entitled to one copy of your personal health information record free-of-charge. Additional copies for you, future releases to you or releases to other persons or facilities may be subject to a reasonable charge (as allowed by state and federal law). Standard fee: $15.00 services fee plus $0.25 per page.

Mailed _____ Faxed _____ Picked up by Patient _____