2020 J Street, Sacramento CA 95811 • Tel: 916-341-0575 • Fax: 916-341-0122

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Version 6

This request concerns health information regarding the treatment of:

Patient Name: ____________________________Date of Birth: _____________ HRN ___________

Address: __________________________ City: ________________ State: ______ Zip: __________

Phone: ____________________________

I authorize the custodian of records of SNAHC or the below mentioned entity to disclose or release the following information: (check all applicable):

☐ Pharmacy/RX ☐ Immunizations ☐ Laboratory/Pathology ☐ Dental Treatment/Notes
☐ Billing ☐ Radiology/Imaging ☐ Emergency Room Discharge Summary ☐ Dental X-rays
☐ Progress Notes

☐ Condition Specific: _____________________

Please disclose the: ☐ Most recent visit ☐ last 30 days ☐ last 6 months ☐ last 1 Year ☐ last 2 Years

*Patients Please Note: **Initial** next to each item if you authorize disclosure of the following protected class information. If not initialed the request for the following items will not be disclosed.

____ HIV/AIDS status ____ Cancer diagnosis ____ Drug or alcohol abuse
____ Psychiatric care ____ Sexually transmitted disease ____ Mental health care

To / From (Please circle one)

Facility: SNAHC
Address: 2020 J Street Sacramento, CA 95811
Telephone: (916) 341-0575
Fax: (916) 341-0122
Attention: Medical Records

To / From (Please circle one)
☐ Patient
☐Facility: ________________________________
Address: ________________________________
Telephone: ______________________________
Fax: ____________________________________
Attention: __MEDICAL RECORDS_______

There is a $5.00 for the first 20 pages, $0.35 for each additional page for each patient access request for medical records.
There is no charge for mailing/faxing copies of a patient health records to other health care facilities for continuation of care.
Please allow 15 business days to process request.

Patient Name: ___________________________Date of Birth: ____________ HRN __________

Name of Provider Requesting Records: ____

Reason for disclosure:

☐ Care by another provider
☐ Attorney
☐ Termination/Transfer of care
☐ Insurance
☐ Social Security/ Disability
☐ Other:_________________
☐ Employment purposes
☐ Verification of Treatment

I understand that I may revoke this consent in writing to the facility and department that the original authorization was made at any time except to the extent that action has been taken in reliance on it. I understand that if the organization I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. [(45 CFR § 164.508(c) (2) (iii)]

I may refuse to sign this authorization and I have a right to receive a copy of this authorization. The Sacramento Native American Health Center cannot refuse treatment for refusal to sign except in limited conditions. If this authorization has not been revoked, it will terminate in one year from the date of my signing unless I have specified a different expiration date or expiration event. (Enter date if different from one year after date below):___________________________

Signature of patient or parent/guardian: ____

Name of parent/guardian: ____

Relationship to patient: ____________ ☐Self **Date must be indicated**: ____________________

Signature of witness/staff: _______________________________Date:______________________

The Federal rules prohibit the individual or organization who receives this information from making any further disclosure unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR, Part 2.