SNAHC
Sacramento Native American Health Center
a californiahealth+ center

2020 J Street, Sacramento, CA 95811
Phone 916.341.0575 Fax 916.341.0122
www.snahc.org

Authorization to Release Records

This request concerns health information regarding:

Patient Name: _____Date of Birth: _____ HRN _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

I authorize S.N.A.H.C or the below mentioned entity to disclose the following information:

☐ Pharmacy/RX ☐ Immunizations ☐ Labs ☐ Dental Notes
☐ Billing ☐ Imaging ☐ Hospital Visit Notes ☐ Dental X-rays
☐ Visit Notes (Med.)

☐_____

Interval: ☐ last visit ☐ last 30 days ☐ last 6 mo. ☐ last 1 Yr. ☐ last 2 Yrs. ☐ _____

Initial next to each item authorized for disclosure. *If not initialed, items will not be disclosed.*

____ HIV/AIDS ____ Substance Abuse/Treatment ____ Cancer
____ Psychiatry ____ Sexually Transmitted Infections ____ Mental Health Care

Person/Organization to Release Information

Name:_____
Address: _____
Telephone: _____
Fax: _____

☐ **Sacramento Native American Health Ctr.**

Person/Organization to Receive Information

Name:_____
Address: _____
Telephone: _____
Fax: _____

☐ **Sacramento Native American Health Ctr.**

Please allow up to 15 business days to process this request.

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Patient Name: _____Date of Birth: _____ HRN _____

S.N.A.H.C. Provider Requesting Records: _____

Reason for disclosure (circle one): Personal *or* Treatment

Signature of patient/patient's legal representative: _____**Date**: _____

Name of patient/ patient's legal representative (print): _____

If needed:

Signature of parent/guardian: _____

Name of parent/guardian (print): _____

Relationship to patient: _____ **Date**: _____

I may refuse to sign this authorization. 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 If this authorization has not been revoked, it will terminate in one year from the date of my signing unless I have specified a different expiration date or expiration event.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 above): _____

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)]

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.