Sacramento Native American Health Center, Inc.
2020 J Street, Sacramento, CA 95814
Phone: 916-341-0575 Fax: 916-341-0122

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
(To Family, Friends, or Caregivers)

Version 2

Patient Name: _____ DOB: _____ HRN: _____

I _____ authorize providers and personnel of SNAHC to discuss my protected health information with:

_____ _____
(Relationship) (Name)

_____ _____
(Relationship) (Name)

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release regarding diagnosis and treatment of the following protected or sensitive information:

____ HIV/AIDS ____ Psychotherapy notes from a Psychiatrist ____ Psychotherapist Treatment for AOD

(Please initial)

_____ I understand this authorization will expire 365 days from the date of signing.

_____ I understand that I have the right to revoke this authorization, in writing, at any time.

_____ I understand that I have the right to refuse to sign this authorization.

_____ I understand this request may take 5-7 business days for processing.

This authorization shall be in force and in effect from until at which time this authorization to use or disclose this protected health information expires.

_____ _____
Signature of Patient/Personal Representative Name of Patient/Personal Representative

Relationship to Patient*: _____ Date: _____
*Legal authority must be verified when an individual is signing on behalf of the patient.

Staff Signature: _____ Date Received by Authorized Official_____
Authorized Official Initials_____