



Auburn Health Center 11670 Atwood Road Auburn, CA 95603
PHONE (530) 887-2800 **FAX** (530) 887-2849 **EMAIL** records@chapa-de.org

Release of Information Form

1	Patient's Last	Patient's First	Date of Birth
2	<input checked="" type="checkbox"/> Please send records <u>from</u> Chapa-De (To Person/Facility Below) *Processed within 15 days <input type="checkbox"/> Please release records <u>to</u> Chapa-De (From Person/Facility Below)		
3	Full Name of Organization/Provider/Individual (or Self)		
	Address		City
	State	Zip	Phone number starting with area code
Send to: <input type="checkbox"/> Mail <input type="checkbox"/> Email: <input type="checkbox"/> Fax:			
4	CHOOSE ONLY ONE (1) Per Release <input type="checkbox"/> Medical <input type="checkbox"/> HIV/AIDS Testing/Treatment <input type="checkbox"/> Alcohol/Drug Use Treatment <input type="checkbox"/> Dental <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Optometry		
5	Time Frame: <input type="checkbox"/> Last Visit <input type="checkbox"/> Past Year <input checked="" type="checkbox"/> All <input type="checkbox"/> Specific Date Range:		
6	<input type="checkbox"/> Progress Notes <input type="checkbox"/> Last Physical <input type="checkbox"/> Medication List <input checked="" type="checkbox"/> Immunization Records <input type="checkbox"/> EKG Reports <input type="checkbox"/> Consult Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Lab Reports <input type="checkbox"/> Charges/Payments <input type="checkbox"/> Dental X-rays <input type="checkbox"/> All records <input type="checkbox"/> Other (Specify) _____		
7	Reason for release: <input checked="" type="checkbox"/> Personal <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Other _____		
Authorization	By signing, I authorize use/disclosure of my health information and understand that: <ul style="list-style-type: none"> ▪ I may revoke this authorization at any time by contacting Chapa-De in writing. ▪ This authorization is valid for 1 year maximum or this earlier date: ___/___/___. ▪ The recipient of your health information may not further disclose your information without obtaining another authorization from you. ▪ All Alcohol & Substance abuse health information is protected and only releasable with a separate express written consent of the person it pertains to. ▪ My treatment/eligibility of care is not based on this authorization. ▪ This authorization is voluntary and a photocopy or fax of this authorization is as valid as the original. ▪ I have the right to a copy of this authorization. 		

SECTIONS 1-7 MUST BE COMPLETED TO BE VALID

Signature

_____ Date: ___/___/___ Tel:(____) _____ - _____

If not patient: Patient's Representative (State Relationship _____)

Internal Use Only: Completed ___/___/___ By: _____ MRN _____