CHOTA COMMUNITY HEALTH SERVICES
Patient Authorization to Release Personal Health Information

Patient Name: _____ Date of Birth: _____

It is a breach of physician-patient confidentiality for my providers to release my medical information in any way with anyone without my expressed consent. In the event that family, friends, or other individuals request any of my medical information, I must grant permission below before they may receive it. By signing this form I am designating Chota Community Health Service (CCHS) to discuss my medical condition with the parties listed below.

I understand and agree that this written authorization does not apply to individuals who I bring with me to my office visit. If I bring an individual to my visit, I am providing consent that they may hear or see details of my medical information. I acknowledge that it is my responsibility to object to the presence of those individuals and will make this objection known to CCHS before any information is discussed. If I change my mind regarding the release of information to any of the listed people, it is my responsibility to inform CCHS in writing of my decision.

In accordance with the above, I hereby authorize Chota Community Health Services to discuss with and release my medical information to the following individuals:

Name(s) of Individuals	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Choose what to release:

	Release	Do Not Release
Medical Office Notes	□	□
Behavioral Health Office Notes	□	□
Psychiatric – Mental Health Office Notes	□	□
Communicable Disease Records	□	□
Drug Abuse / Alcoholism Records	□	□
Sickle Cell Anemia Records	□	□
AIDS / HIV Records:	□	□
Other (please specify): _____	□	□
Can pick up test results? (labs, x-rays, etc.)	□	□
Can pick up my prescriptions?	□	□

I understand that this consent may be withdrawn by me, in writing, except to the extent authorized information has been disclosed in reliance upon it. In any event, this consent shall expire in 99 years unless I update or revoke it. I also understand my disclosure made on my behalf by this facility is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse records as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____ _____

Patient or Parent/Guardian Signature Relationship Date

_____

Print Name

Office Use Only - If this form is filled out by the guardian, proof of guardianship must be on file. Verification of guardianship on file by : _____date:_____

For Minors, please fill out this additional information:

Father/Legal Guardian Name: _____ Release Information? □Yes □No*

Mother/Legal Guardian Name: _____Release Information? □Yes □No*

***NOTE:** Unless legal papers for medical custody of minors is on file we are required to release medical information to both parents. Guardians must also have legal paperwork on file. An answer of "No" here is only valid if we have legal custody paperwork on file to support it.*