RELEASE OF PROTECTED HEALTH INFORMATION FORM

Completion of this Authorization Form allows AltaMed Health Services to release your protected health information to the entity named below. **Failure to complete all sections of this form may invalidate this request.**

RELEASE INFORMATION TO:

Entity:
Address:
Phone:

PATIENT INFORMATION:

Pt. Name:	Pt. Date of Birth:
Date(s)of Service: ________ to ________ All______	Telephone No:
Pt. Chart #:	Pt. Account #:

TYPE of INFORMATION - Indicate type of information to be released.

All released information complies with one or more of the following:

- *Confidentiality of Medical Information Act of 1981, Civil Code Section 56 et seq*
- *Health and Safety Code Sections 120980 (g)*
- *Health and Safety Code Section 11977*
- *42 U.S.C. Section 2900dd-2*
- *California Federal Regulations Part 2*

______ Medical information compiled during the dates of services indicated above.

______ Test results that detect the presence of the human immunodeficiency virus (HIV)

______ Medical records obtained in the course and the diagnoses and treatment for alcohol and/or drug abuse.

______ Other: ____

RESTRICTIONS:
I understand that the requestor of this information may not further use or disclose the requested medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

EXPIRATION:
This authorization shall be come effective immediately and will expire six (6) months from date of signature.

Expiration Date: ______ / ______ / ______

CANCELLATION of AUTHORIZATION:
You may cancel this authorization at any time. If you choose to cancel this request, it must be placed in writing and signed by you or your legal representative and sent to the following address:

AltaMed Health Services
Attn: Privacy Officer
500 Citadel Drive – Suite 490
Commerce, CA 90040

AUTHORIZATION:

_______________________________ _______________________
Signature *Date*

If signed by someone other than the patient, indicate relationship to the patient:

____
Relationship

____
Witness