CONTRA COSTA HEALTH SERVICES
CONTRA COSTA REGIONAL MEDICAL CENTER
CONTRA COSTA HEALTH CENTERS

AUTHORIZATION FOR CCHS TO DISCLOSE MEDICAL INFORMATION

PATIENT NAME: FIRST / MIDDLE / LAST		DATE OF BIRTH	RECORD #
AKA (OTHER NAME)			
STREET ADDRESS	CITY STATE ZIP		AREA CODE PHONE# ( )

I am the ☐ **PATIENT** ☐ **GUARDIAN** ☐ **CONSERVATOR** ☐ **DESIGNEE** and hereby authorize Contra Costa Health Services to disclose medical records for the above named patient to:

SEND TO (NAME OF PERSON, ORGANIZATION, AGENCY)			
STREET ADDRESS	CITY STATE ZIP		AREA CODE PHONE# ( )
PURPOSE: THE DISCLOSURE OF THESE RECORDS IS FOR THE FOLLOWING PURPOSE(S) ONLY			
VISIT or ADMISSION / DISCHARGE DATES OR OTHER DATES FOR PURPOSE OF THIS INFORMATION RELEASE			

RESTRICTIONS: I understand that the recipient of this information **may not** further use, transfer nor redisclose the medical information to any person or entity unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

INFORMATION TO BE RELEASED: This authorization is for **full disclosure of all records**, including Clinical Findings, Diagnosis, Treatment, Assessment, Recommendations for Further Care, Names of Health Care Personnel, Dates of Hospitalizations and Ambulatory Visits, Charges, and any information which may be related to Drug, Alcohol, or Psychiatric conditions or treatment and/or Sexually Transmitted Disease, including AIDS and HIV Test Result information. Such record will be disclosed unless you specify information you wish excluded. Please initial below information you do not want released:

_____ No Exclusions
INITIAL

Exclude:
_____ Exclude HIV test results
INITIAL

_____ Exclude Substance Abuse information
INITIAL

_____ Exclude Psychiatric information
INITIAL

_____ Exclude other information: _____
INITIAL SPECIFY

DURATION: This authorization shall become effective immediately and shall remain in effect for one year or until _____, whichever comes first. This consent is also subject to revocation by the undersigned at any time between now and the release of information by the sending person, agency, or institution.

RIGHT TO A COPY OF AUTHORIZATION: I understand that I have a right to receive a copy of this authorization.

Please take a copy after signing. ☐ **YES,** I have taken my signed copy of this form.

DATE	PATIENT SIGNATURE		SIGNATURE OF HOSPITAL STAFF WHEN REQUIRED (AB510, MH)	
SIGNATURE OF PARENT, GUARDIAN, CONSERVATOR, DESIGNEE		RELATIONSHIP	EMPLOYEE NAME	DATE

A photocopy of this release is as valid as the original.

Original Chart
Copy Recipient
Copy Patient