Woodland Healthcare
CHW

Release of Information Department
1207 Fairchild Court
Woodland, CA 95695-4398
Tel. (530) 668-2605 Ext. 6745
Fax (530) 662-7438

WOODLAND CLINIC'S AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide *all* information requested may invalidate this authorization.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Name of Patient:_____ Date of Birth:_____

Other Names: _____ Telephone Number: _____

Address: _____ City/State/Zip: _____

Medical Record or Account #:_____
(Facility use only)

I AUTHORIZE :

☐ Woodland Clinic Medical Group
1207 Fairchild Court
Woodland CA 95695
*Dr:*_____

☐ West Court Clinic
239 W. Court Street, Suite B
Woodland CA 95695
*Dr:*_____

☐ Davis Medical Group
2330 W. Covell Blvd.
Davis CA 95616
*Dr:*_____

TO DISCLOSE TO: _____
(Persons/organizations authorized to ***receive*** the information)

at the following address:_____
(street, city, state and zip code)

☐ **THE FOLLOWING RECORDS,** specific types of health information, or records for the date(s) of treatment as specified:

DATES OF SERVICE: _____

☐ Physician Notes
☐ Nurse Notes
☐ X-ray Reports
☐ Laboratory Tests
☐ Physical Exam
☐ Discharge summary
☐ Consultation Reports
☐ Operative Reports

☐ Other: _____

☐ **THE FOLLOWING INFORMATION** contained in the records specified below **(Initial applicable lines and boxes below):**

____Mental health or developmental disability treatment records (excludes "psychotherapy notes")

____Substance abuse treatment records

____HIV test results (This authorizes disclosure of laboratory test results only. **Note that your records may include information concerning your HIV status <u>even</u> if you do not check this box.)**

☐ **ALL RECORDS** regarding my treatment, hospitalization, and outpatient care. ***A separate authorization is required for the use or disclosure of psychotherapy notes or research health information.***

PURPOSE: The purpose and limitations (if any) of the requested use or disclosure is:

☐ At the request of the patient or personal representative; ***OR***

☐ Other: _____

EXPIRATION: This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified: _____
(insert date)

MY RIGHTS:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address ***Woodland Healthcare, Release of Information Dept. 1207 Fairchild Ct., Woodland CA. 95695.*** My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA). If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R. part 2.

SIGNATURE:_____ Date:_____
(Patient or personal representative)

_____ _____
Print name of personal representative Relationship to patient

Patient/Representative Identification Verified. *Initials:*_____ *Dept:*_____

⇨ PICTURED I.D. MUST BE PRESENTED ⇦