axiscommunityhealth

AUTHORIZATION FOR RELEASE AND/ OR DISCLOSURE OF BEHAVIORAL HEALTH INFORMATION

INSTRUCTIONS: Please review and complete this form carefully. This form will be processed by medical records. Please mail or hand deliver this completed form to the following address: Axis Community Health, ATTN: Medical Records, 4361 Railroad Avenue, Pleasanton, CA 94566 or via fax at (925) 462-1650.

PATIENT'S INFORMATION		
Name:	Axis Medical Record #:	
Birthdate:	Phone Number:	Request Date:
Address:		
PHI MAY BE DISCLOSED BY:		
Person (Name or Title):	Facility or Program Name:	
Address:	Telephone:	Fax #:
PHI MAY BE DISCLOSED TO:		
Facility or Program Name	Name of Recipient Required if relationship to patient is 'Other'.*	Relationship to Patient
		☐ Treating Provider
		☐ Third-Party Payer
		☐ Other (Add name of recipient*)
Address:		

Method of Disclosure:

☐ Mail:_____

☐ Email:_____

☐ Fax:_____ ☐ Phone:_____

☐ Other:_____

Will information be shared both ways between the two parties mentioned above?

☐ Check if yes

PHI USAGE

By signing this form, I authorize the use and disclosure of the requested protected health information to be used for the following purposes:

☐ Coordination of Care

☐ Other:

PERSONAL HEALTH INFORMATION TO BE DISCLOSED

☐ Mental Health, or Drug & Alcohol Program: Initial Assessment/Intake, Treatment Plans, Diagnosis, Discharge Plan

☐ Psychiatric Evaluation, psychiatric medications, psychiatric intake and discharge forms

☐ Results of Psychological Testing or Screening

☐ DUI attendance and participation, progress and recommendations for treatment

☐ Other: _____

NOTE: Behavioral health records are typically released to other agencies for the purpose of coordination of care, or to verify completion of treatment. Behavioral health records requested to be released to the patient directly will undergo an internal review process. Hospital and Medical records being sent to Axis may include disclosure of mental health, alcohol/drug information as a part of this authorization.

The treatment records for mental health, or alcohol/drug departments are specifically protected, and will not be disclosed unless you sign below.

☐Alcohol/Drug Records ►Signature: _____

☐Mental Health Records ►Signature: _____

Provider Approval Signature Required: _____

Provider Name: _____ Date: _____

Disclosures: As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), 42 CFR Part 2 and California law, this practice may not use or disclose your individually identifiable health information, except as provided in our Notice of Privacy Practices, without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described herein. The exceptions are set forth in the Notice of Privacy Practice and Informed Consent Documents.

I also understand that violation of the federal law and regulations by a part 2 program is a crime and that suspected violations may be reported to the appropriate authorities consistent with section 2.4, along with the contact information. For Alameda County, Northern Judicial District in California, the contact information is: United States Attorney's Office Federal Courthouse, 1301 Clay Street, Oakland, CA 94612; Phone: 510-637-3724.

Right to Revoke: I understand that my Representative or I may revoke this authorization in writing at any time. I understand my revocation will NOT affect any disclosures that occurred before Axis Community Health received and processed a written notice of revocation. I understand that if I do not revoke the authorization, this authorization will expire one year from the date of signature below. Note: If this authorization is for a minor, the expiration date cannot exceed the 18th birthday of that minor. To revoke this authorization, I understand that I must send a written request to Axis Community Health, ATTN: Clinic Operations Manager, 4361 Railroad Avenue Pleasanton, CA 94566 or via fax at (925) 462-1650.

List of Disclosures: You have a right to obtain a list of entities that received your information in the previous two years under a general designation consent. You must submit this request in writing to the address noted above.

Effect of Refusal to Sign Authorization: This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

ACKNOWLEDGEMENT

I authorize the disclosure of my personal health information to the persons/entities as described. I understand this authorization is voluntary, and made to confirm my directions. I understand that if an electronic copy of information is requested, it can be produced in the form requested if it is readily producible. If disclosure is requested to be sent by email or "other" method, I understand that email addresses and "other" methods can be accessed by others who may or may not be authorized by me to view my nonpublic health information and I indemnify Axis Community Health from such unintentional disclosure. I further understand that I have a right to receive a copy of this authorization form. I hereby give permission to Axis Community Health and/or the person/facility indicated on this form to disclose, release and use my personal health information in the manner described herein.

By: _____ _____

Patient's Name (Print) Patient's Signature Date

If you are not the patient, please also complete, sign and date below. Check the box that describes your relationship to the patient. Please attach proof or your relationship to the patient (e.g. Power of Attorney, legal guardian) if we do not currently have this on file.

By : _____ _____

Representative's Name (Print) Representative's Signature Date

- ❑ Parent or guardian of minor patient (to the extent minor could not have consented to the care)
- ❑ Guardian or conservator of an incompetent patient
- ❑ Beneficiary or personal representative of deceased patient
- ❑ Spouse or person financially responsible (where information is solely for purpose of processing application for dependent health care coverage)

Authorization Tracking Information

For Axis Use Only:	
Date received:	Processed by:
Completion Date:	File Date: