AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/ FAMILY MEMBERS

For Clinic Use Only

This document allows you, the patient, to assign the people in your care team. Your "care team" is made up of those people who help you with your personal care. This can be your family, friends, or caregivers. When you add someone to your care team, you are authorizing them to communicate and interact with Axis on your behalf, to the extent that you specify in this document. It's important to know that the person on your care team is not the same as your Personal Representative. Personal Representatives are a legal designation, and they have much broader authority to act on your behalf – i.e., sign consent forms. **If you are completing and signing this form on behalf of another person, you should provide your own name, signature, and your relationship to the patient where indicated at the end of the form.**

A. PATIENT INFORMATION.

PATIENT NAME:	
PATIENT ADDRESS:	
PATIENT SOCIAL SECURITY:	PATIENT DATE OF BIRTH:

B. GRANTING AUTHORIZATION.

By completing this form, you are requesting for additional individual(s) to be part of the patient's care team. The person indicated in Part A, above, hereby authorizes Axis Community Health to use and disclose health information to the Authorized Individual(s) listed in Section D below.

C. HEALTH INFORMATION TO BE USED OR DISCLOSED

Select the task(s) that the care team is authorized to perform for the patient:

◯ Pick up medical records (only patients or their Personal Representatives can sign consent to request medical records).

◯ Pick up medications

◯ Call for diagnostic/lab results

◯ Create and cancel appointments

◯ Speak with my provider about my care, except for _____.

* Any sensitive health information pertaining to psychotherapy notes, mental health records (protected by the Lanterman-Petris-Short Act), drug and/or alcohol abuse records may not be released.

◯ Other: _____.

D. AUTHORIZED INDIVIDUALS

This health information may be disclosed to: List the individuals you would like to add to the patient's care team. Allowed tasks will be limited to the scope specified above.

Name	Date of Birth	Relationship to Patient	Phone Number

I understand that I may cancel this authorization at any time by notifying Axis Community Health in writing. I understand that this authorization remains in effect until I cancel my authorization. If I cancel my authorization, it will not affect actions taken by Axis Community Health prior to their receipt of my cancellation. I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

Effect of Refusal to Sign Authorization: I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.

E. ACKNOWLEDGEMENT

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) 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 above. Please review and complete this form carefully. It may be invalid if not fully completed.

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 once the information is disclosed, it may be re-disclosed and no longer protected by privacy regulations 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 to disclose, release and use my personal health information in the manner described herein.

_____	_____	_____
Print Name	Signature	Date

If you are completing and signing this form on behalf of another person, please indicate your relationship to the patient and provide the documentation indicated for the relationship:

Relationship to Patient (select one):

- ◯ Self
- ◯ Caregiver for an adult patient (both patient and person requesting must sign Acknowledgement)
- ◯ Durable Power of Attorney for Healthcare for a disabled adult (DPOA)**
- ◯ Legal Guardian of a disabled adult patient**
- ◯ Adult child of a senior parent (both patient and person requesting must sign Acknowledgement)
- ◯ Adult child of a disabled parent**
- ◯ Parent of a disabled adult patient**

*** Please provide a copy of legal paperwork verifying the requestor's relationship with the patient.*