axiscommunityhealth

# AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL OR DENTAL 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 Suite E, 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:**

Name of Clinic or Other Provider:
Phone Number: Fax Number:

**PHI MAY BE DISCLOSED TO:**

☐ **Patient or Personal Representative**

How do you want to receive your records?

- ☐ Mail
- ☐ Email
- ☐ Pick-Up
- ☐ Fax

☐ **Facility Information**

Facility Name: _____
Attention: _____
Address: _____
_____
Phone Number: _____
Fax Number: _____

**PERSONAL HEALTH INFORMATION TO BE DISCLOSED**

a. ☐ All health information pertaining to my medical or dental history, mental or physical condition and treatment received; or

☐ Only the following records or types of health information (including any dates):

_____

b. ☐ I specifically authorize release of HIV test results _____(initial)

**PURPOSE**

Purpose of requested disclosure: ☐ Patient request OR ☐ Other: _____

Limitations, if any:

## 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 inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: Axis Community Health, Attn: Medical Records Department, 4361 Railroad Avenue, Suite E, Pleasanton, CA 94566 or via fax at (925) 462-1650. 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 redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law

## EXPIRATION

If I do not revoke the authorization, this authorization will expire 1 year from the date of signature below.

**SIGNATURE**

Patient's Name (print):_____

Signature: _____ Date:_____

(*Patient/Legal Represenative)*

If signed by a person other than the patient, indicate relationship:_____

***Please attach proof of your relationship to the patient (i.e. Power of Attorney) if we do not currently have this on file.**

Print Name:_ (*Legal Representative)*

## Authorization Tracking Information

*If request is for BH (MH/IBH/SUD) records, please have requestor complete the Authorization for Release of Behavioral Health Information.*

| ***For Axis Use Only:*** | |
|---|---|
| Date received: | Processed by: |
| Completion Date: | File Date: |