Redwoods Rural Health Center
PO Box 769, 101 West Coast Rd., Redway, CA 95560
Phone: (707) 923-2783, Fax: (707) 923-2543

Authorization For Use or Disclosure Of Protected Health Information

Full Legal Name of Patient: _____

Date of Birth: _____

I hereby authorize RECORDS COMING FROM:

Name: _____

Address: _____

City, State, Zip: _____

Phone:_____ Fax:_____

To release RECORDS GOING TO:

Name: _____

Address: _____

City, State, Zip: _____

Phone:_____ Fax:_____

Information authorized for use or disclosure, or to be obtained:

- ☐ Progress Notes
- ☐ Lab Reports
- ☐ X-ray Reports
- ☐ All health information between _____ (date) to_____(date)

I specifically authorize release of the following information subject to special confidentiality protections:

- ☐ ____ Mental Health/Development disability
- ☐ ____ HIV/AIDS **INITIAL IF YOU WISH TO INCLUDE**
- ☐ ____ Alcohol or substance abuse diagnosis, prognosis, or treatment

Mark the purpose of the requested use or disclosure:

- ☐ Insurance
- ☐ Continued treatment
- ☐ Legal
- ☐ At the request of the patient or patient's representative
- ☐ Other (specify): _____

I understand:

- RRHC is committed to protecting personal health information and acts in accordance with Notice of Privacy Practices.
- I may revoke this authorization at any time, in writing, except revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be 6 months from date of signature.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information. I understand that information disclosed pursuant to this authorization could be re-disclosed by the recipient. I may inspect or obtain a copy of the health information that I am authorizing to be disclosed.
- I understand that you may charge me reasonable costs incurred, including clerical costs and postage costs for mailing the records.

_____ (_____)_____ _____ /_____ /____
Signature of Patient Phone Number Date

_____ _____ /_____/_____
Signature of Personal Representative, Parent, Legal Representative (circle one) Date

Records copying charge is $20.00 for legal copies and 25¢ per page for patients' copies.
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