OMNI FAMILY HEALTH

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

(866)707 - OMNI (66 64) www.OmniFamilyHealth.org

All Sections must be completed for the authorization to be honored. Use "N/A" if not applicable.

I. PATIENT INFORMATION

Last Name:_____ First Name:_____ Date Of Birth: _____

Address:_____ City/State/Zip:_____

II. Individual/ Organization Authorized to Release Medical Health Information

Name: _____

Address_____ City/State/Zip:_____

III. Individual Organization to Receive the Information

[45 C.F.R. § 164.508 (c)(1)(ii), (iii) & Civ. Code §56.11 (e), (F)]

The undersigned hereby authorizes Omni Family Health Medical Information Management to release the Health Information pursuant to the Authorization.

Name: _____

Phone:_____ Fax:_____ E-mail:_____

Address_____ City/State/Zip:_____

IV. Authorization Expiration or Written Correspondence

[45 C.F.R. § 164.508 (c)(1)(v) & Civ. Code § 56.11 (h)]

Unless otherwise revoked by the patient, this authorization for release of health information to the above-named individual/organization will expire of the date specified below or **12 months** from the date signed in section IX, whichever occurs first.

Date of Expiration:_____ Initial: _____

V. Health Care Records To be Released – General

[45 C.F.R. §164.508 (c)(1)(i) & Civ. Code §56.11 (d), (g)]

I authorize records for the following period of time to be released (must be completed to receive records):

From (mm/dd/yyyy):_____ To (mm/dd/yyyy): _____

☐ All Health Information pertaining to my medical history ☐ Dental Records ☐ Other: _____

VI: Health Records to be Released – Specify

[45 C.F.R. §164.508 (c)(1)(i) & Civ. Code §56.11 (d), (g)]

☐ Behavior/Mental Health Records From:_____ To:_____

☐ HIV/AIDS/Sexual Transmitted Diseases (STD) From:_____ To:_____

☐ Substance Use Disorder Information From:_____ To:_____

☐ Gender affirming healthcare Information From:_____ To:_____

☐ Health Genetic Testing From:_____ To:_____

VII. Purpose for the Release or Used of the Information

[45 C. F.R. § 164.508 (c)(1)(iv)]

☐ Health Care ☐ Personal Use ☐ Legal ☐ Other (please specify) _____

VIII. Authorization Information

I understand the following:

1) I authorize the use or disclosure of my individually identifiable protected health information as described above for the purpose listed. I understand this authorization is voluntary.

2) I have the right to revoke this authorization. To do so, I understand that I can submit my request in writing to 4900 California Ave, Health Information Management (Medical Records). The authorization will stop further release of my protected health information on the date my valid revocation request is received by the Health Information Management. [45 C.F.R § 164.508 (c)(2)(i)]

3) I am signing this authorization voluntarily and understand that my health care treatment will not be affected if I do not sign the authorization. [45 C.F.R § 164.508 (c)(2)(ii)]

4) Under California law, the recipient of the protected health information under the authorization is prohibited from re-disclosing the protected health information, except with a written authorization or as specifically required or permitted by law. [Civ. Code § 56.13]

5) If the organization or person I have authorized to receive the protected health information is not a health plan or health care provider, the release of information may no longer be protected by federal and state privacy regulations. [45 C.F.R § 164.524 (a)(2)(v)]

6) I have the right to receive a copy of this authorization. [45 C.F.R § 164.508 (c)(4) & Civ. Code § 56.11(i)]

7) Reasonable fees may be charged to cover the cost of copying and postage related to releasing this protected health information [45 C.F.R. § 164.524 (c)(4) et seq. & California Health and Safety Code § 123110, et seq.]

8) I understand that my substance use disorder records are protected under the federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R., Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

IX. Patient Signature

[45 C.F.R. § 164.508 (c)(1)(vi) & Civ. Code § 56.11 (c)(1)]

Name (Print): _____

Signature: _____ Date: _____

NOTE: If no expiration date is specified in section IV, this authorization will expire 12 months from this date.

X. Requestor's Identifying Information

[45 C.F.R. § 164.508 (c)(1)(vi) & Civ. Code § 56.11 (c)(1)]

NOTE: You Must Attach Legal Documentation to Verify That You Are the Parent, Conservator, Guardian, Executor of a Decedent's Will, or Have Medical Decision-Making Authority for the Individual.

Name of person signing form, if not patient (Print): _____

Signature: _____ Date: _____

Describe authority to sign form on behalf of patient: _____ Date: _____

Submission Instructions: *You may submit this form by delivering it to any Omni Family Health Center or emailing it to: medicalrecords@omnifamilyhealth.org.*