Community First Health Centers
Improving the quality of life for our community.

Office Use Only

Date Received: _____ **Provider Initials:**_____

Date Released:_____ **Staff initials who sent info.**_____

Authorization to Disclose/Release Protected Designated Health Record Set Information

Please complete this form in its entirety so we can help you receive the information you are requesting.

1. **This authorization is voluntary. I understand that Community First Health Centers will not base treatment, payment, enrollment, or eligibility for benefits on my signing this document**.

Patient Full Name: _____ Maiden/AKA: _____ Date of Birth:_____

Street Address: _____

City/State/Zip: _____ Telephone #:_____

Email Address: _____

2. **[ ] Myself:** I request Community First Health Centers to release my protected health information to Myself.
   Select delivery method: [ ] Email [ ] Pick up in office [ ] US Mail (to address listed above) [ ] Fax:_____
3. **[ ] Other:** I am the patient, or legal authorized representative of the patient listed above and request Community First Health Centers to release my protected health information(or the patient information listed above)to:

Individual/Person: _____ Company/Organization: _____

Street Address: _____

City/State/Zip: _____ Telephone #: _____

Fax #:_____

Select delivery method: [ ] **Fax** [ ] **US Mail** [ ] **E-mail**_____

4. **Purpose of release/disclosure to other person/organization:**

Reason for Disclosure
[ ] Continuation/Transfer of Care
[ ] Attorney/Legal
[ ] Insurance Company
[ ] Workman's Compensation
[ ] Patient Directive
[ ] Other (specify):_____

5. Records to be released:

I hereby authorize Community First Health Centers to release/receive any and all medical records and information as specified below, relating to my care and treatment which may include x-rays, photographs, electronic and digital files and any other records, unless I expressly direct or specify otherwise. I understand that medical information may include records if any, relating to treatment for alcohol and drug abuse protected under the regulations in 42 C.F.R. Part 2; psychiatric/ psychological services and social work records, and any information regarding communicable diseases and infections, defined by Michigan Department of Public Health rule, which can include tuberculosis venereal diseases, sexually transmitted diseases, acquire immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or AIDS-Related Complex (ARC). This does not include psychotherapy notes.

Information to be released (be specific):

[ ] Only medical records (The Designated Record Set) from date(s) of service listed:_____
[ ] X-Ray Results (Specify date(s): _____ [ ] Lab Results (Specify date(s): _____
[ ] Other Records or Information (Specify):_____
[ ] Entire Medical Record (The Designated Record Set) :_____
Check below for any **EXCLUSION**:
[ ] Alcohol/Substance Abuse [ ] Mental Health Records [ ] HIV/AIDS
[ ] Other (specify):_____

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6. Release of records TO Community First Health Centers:

[ ] I authorize release of records to Community First Health Center ATTN: Medical Records, 1011 Military Street, Port Huron, MI, 48060 – Fax # 810-488-8005 from:

[ ] I authorize release of records to Community First Health Centers ATTN: Medical Records, 555 St. Clair River Drive, Algonac, MI, 48001 – Fax # 810-794-7645 from

[ ] I authorize release of records to Community First Health Centers ATTN: Medical Records, 58144 Gratiot Avenue, P.O. Box 480430, New Haven, MI. 48048 – Fax # 586-749-5560 from:

Office Use Only

Send Medical Records Via:

[ ] US Mail [ ] Fax [ ] Email

From:

Name:_____

Street Address: _____

City/State/Zip: _____Telephone #: _____

Fax #: _____

7. I may revoke this authorization in writing by sending a written notice to the Community First Health Centers location where you received services addressed to the attention of Medical Records. A request to revoke an authorization would not affect any actions already taken by Community First Health Centers based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may inspect or copy (at additional expense) the information to be used or disclosed, as provided in CFR 164.524. **This authorization expires upon my revocation of this consent or within one calendar year of being signed. If you wish to have this authorization expire before one calendar year, please indicate the date of expiration here**: _____.

8. To protect your health record information, any information requested to be sent by email will be encrypted and password protected unless it is requested otherwise. Communications sent by email over the Internet are not always secure and may be intercepted and read/ received by someone other than who it was addressed to. Choosing to have the requested health information by email implies that you accept this risk.

_____ _____ _____ _____

Patient or legally authorized individual Signature **Print Name** **Date** **Time**

[ ] Translation Provided

_____ _____

Witness signature **Date**

The Standards for Privacy of Personally Identifiable Health Information, 45 CFR Parts 160 and 164, states that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient of this information. The federal confidentiality Rules CFR Part 2 prohibit making any further disclosure of drug or alcohol information unless further disclosure if this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 1. 11/14/2018

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