Authorization to Disclose Protected Health Information

***FOR VERIFICATION OF IDENTITY PLEASE PROVIDE A COPY OF ONE OF THE FOLLOWING: DRIVERS LICENSE, PASSPORT, ID CARD, ETC.**

A. Patient Name_____ **Date of Birth**_____ **CHP ID**_____
Address_____ **City**_____ **State**_____ **Zip**_____
Verification of Identity* (Attach)_____ **Phone Number**_____

If you are the personal representative of the patient and are authorizing the disclosure of protected health information on the patient's behalf, complete Section B below:

B. Representative Name_____ **Relationship to Patient**_____
Verification of Identity (Attach)_____ (Power of Attorney, Healthcare Surrogate, etc.)

C. By signing this form, I _____ authorize _____ to release the specified protected health information via (check one) ☐ mail (hardcopy) ☐ unsecured email ☐ secured email ☐ unsecured electronic format (USB) ☐ secured electronic format (USB) ☐ Pick-Up:
Name_____ **Phone Number**_____
Address_____ **City**_____ **State**_____ **Zip**_____
Email _____ **Dates to be Released** _____
Purpose for Release_____

D. Records to be Released:

☐ All Medical Records including the items listed below.

*** Authorizing the release of the items below is not an admission of any such record. This is only an authorization of any/all records to be provided in the event of any such discovery. Check if you **do not** authorize the release.

☐ Mental Health/Psychotherapy Notes ☐ Substance Abuse/Alcohol Abuse Mental
☐ HIV/AIDS ☐ Sexually Transmitted Diseases

☐ Immunization Records **ONLY**

☐ Medical Records created by other health care providers not associated with CHP including hospital records.

☐ Medical Records of the same type listed above for disclosure, created after today's date, until the expiration date shown below or one (1) year from the date of this authorization, whichever comes first.

E. I understand that once information is disclosed, the information is subject to re-disclosure and may no longer be protected by federal privacy regulations. I hereby release CHP and its employees from any and all liability that may arise from the release of information as I have directed. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Enterprise Content & Medical Record Management Department. I understand that revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my plan when the law provides my plan with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one (1) year from the date signed below. I understand that authorizing the disclosure of this health information is voluntary and can be delivered in a secured or unsecured format. If secured, the password to access my records will be mailed separately. I do not need to sign this form in order to assure treatment, payment of treatment, or enrollment.

F. Signature of Patient/Legal Representative_____ **Date**_____ **Expiration Date**_____
(Otherwise the expiration will be one year from the date indicated above)

Revision History

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