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 the section below:

Representative Name________________________________**Relationship to Patient**_________________
Verification of Identity (Attach)________________(Power of Attorney, Healthcare Surrogate, etc.)

B. By signing this form, I _________________________ authorize _______________________to release the specified protected health information below via (check one) _____mail (hardcopy) ______ unsecured email ______ or unsecured electronic format (CD) to:

Name____**Phone Number**_________________________
Address_____________________________________**City**_______________**State**________**Zip**_________
Email ____**Dates to be Released** ___________________
Purpose for Release____

Medical Records created by __________________________________ including (check all that apply):

- ☐ Mental Health/Psychotherapy Notes
- ☐ Substance Abuse/Alcohol Abuse
- ☐ HIV/AIDS/Sexually Transmitted Diseases
- ☐ Genetic Disorders
- ☐ Eye Care: ____
- ☐ Medical Records created by other health care providers including hospital records which may be included in the health information described.
- ☐ Medical Records of the same type listed above for disclosure, created after today's date, until the expiration date shown below or six (6) months from the date this authorization, whichever comes first.

C. 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 six (6) months from the date signed below. I understand that authorizing the disclosure of this health information is voluntary and if checked will be delivered in an unsecured email or electronic format and 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.

D. Signature of Patient/Legal Representative______________________**Date**_________**Expiration Date**____________
(Otherwise the expiration will be six months from the date indicated above)

Revision History

Compliance Committee Approved Date:12/17/2002 QMIT 12/19/2002 Provisional Approval Date: 3/25/2020
Reviewed Only: 2/16/2010, 12/6/2018
Revised: 9/2008, 4/30/2013, 8/20/2013, 2/17/2015, 8/23/2016, 7/22/2019, 3/20/2020
Policy Location (s): Compliance Intranet – Compliance Forms