For Office Use ONLY
PCC Label

Authorization for Release of Information

Patient Name:		Date of Birth: ____ / ____ / _____
Address:		Driver License #:
City:	State:	Zip Code:
Phone #:	Email (optional):	

I hereby authorize: (check one)

☐ Redding Rancheria Tribal Health Center (RRTHC)
1441 Liberty St, Redding CA 96001

☐ Churn Creek Healthcare (CCHC)
3184 Churn Creek Rd, Redding CA 96002

☐ Central Valley Healthcare (CVHC)
4174 Ashby Court, Shasta Lake CA 96019

☐ Trinity Health Center (THC)
81 Arbuckle Court, Weaverville, CA 96093

☐ Other: _____
Name of Provider / entity to RELEASE health records

_____
Street Address, City, State, Zip Code Phone # Fax #

To release information to Recipient: (check one)

☐ Redding Rancheria Tribal Health Center (RRTHC)
1441 Liberty St, Redding CA 96001
Fax: 530-224-2742

☐ Churn Creek Healthcare (CCHC) 3184
Churn Creek Rd, Redding CA 96002
Fax: 530-722-4151

☐ Central Valley Healthcare (CVHC)
4174 Ashby Court, Shasta Lake CA 96019
Fax: 530-262-6030

☐ Trinity Health Center (THC)
81 Arbuckle Court, Weaverville, CA 96093
Fax: 530-623-0025

☐ Patient or Legal Representative

☐ Other:

_____
Name of Provider / person / entity to RELEASE health records

_____
Street Address, City, State, Zip Code Phone # Fax #

Purpose of requested use or disclosure:

☐ Personal use ☐ Seeing a specialist ☐ Getting a second opinion
☐ Continuity of Care ☐ Switching doctors ☐ Other: _____

Date range of information to release:

☐ Past 6 months ☐ Past 2 years ☐ Dates: _____ to _____
☐ New Patient: Last 3 visits **(If establishing care with our facility please check this box)**

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Information to be released:

☐ New Patient: Last 3 chart notes seen	☐ Current History & Physical
☐ Current Medication List	☐ Current Problems List
☐ Progress Notes	☐ Lab Results
☐ X-Ray/Imaging/Diagnostic reports	☐ Other:
☐ Immunization Records	☐ Other:

I approve the release of the following protected or sensitive information: (initial REQUIRED)

☐ Mental Health Notes	Initial _____	☐ Sexually Transmitted Diseases	Initial _____
☐ Alcohol or Drug Treatment/Referrals	Initial _____	☐ Psychiatric Notes	Initial _____
☐ HIV/Aids test results	Initial _____	☐ Other:	Initial _____

Format for Records: (select 1 option ONLY)
Please note, if a format is not selected, records will be provided in USB Flash Drive form.

☐ Fax	☐ Email (encrypted)	☐ Email (unencrypted)*	☐ Paper by Mail
Per page fee may apply:		☐ Paper by In-Person Pickup	☐ USB Flash Drive

**Sending information by unencrypted email increases the risk of being read by an unauthorized third party.*

Your Rights: I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have the right to cancel this authorization at any time. I understand that if I cancel this authorization, I must do so in writing and present my written cancellation to the Medical Records Department. I understand that it will not apply to information that has already been released in response to this authorization. I understand that the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or have copied the information to be used or disclosure, as provided in CFR 164.524. I understand that the information disclosed may be re-disclosed and that the re-disclosure may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the Medical Records staff at the below facilities:

RRTHC & CV @ 530-224-2700 **CCHC & THC @ 530-768-2436**

I understand that I have a right to receive a copy of this authorization form.

Expiration of Authorization: Unless otherwise revoked, this authorization expires ____ / ____ / _____. If no date is indicated, this authorization shall remain in effect for one (1) year after the signing of this form.

Signature: _____ **Date:** _____

If Legal Representative (List relationship to the patient or authority to act)

Printed Name: _____ **Relationship:** _____

Witness (if applicable): _____

Office Use Only:	ROI Faxed/Sent:	PHI Log:
Reviewed by (print name):	Date:	Released: ☐ YES ☐ NO