TCSIG Wellness Center
1174 Live Oak Boulevard
Yuba City CA, 95991
Phone: (530) 822-5500 Fax: (530) 822-5503

Patient Authorization Form to Release and Request Medical Records (PHI)

Required for all Authorizations for Release of PHI or Right to Access

Patient Name:	Birth Date:	Social Security No. *(optional)*:
Patient's Address:	Requestor's Name/Phone Number (if patient is not the requestor):	
PHI Recipient Name:	Address/City/State/Zip	Phone Number: (__) _____ Fax Number: (__) _____
PHI Sender Name:	Address/City/State/Zip	Phone Number: (__) _____ Fax Number: (__) _____

This authorization will expire on the following: (Fill in the Date or the Event, but not both.)
Date: Event:

Purpose of Disclosure:

Is this request for psychotherapy notes?
☐ Yes, then this is the only item you may request on this authorization.
☐ No, then you may check as many items below as you need.

Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
☐ All PHI in record ☐ History and Physical ☐ Consult Report ☐ Operative Report ☐ Progress Notes		☐ Physician Orders ☐ Laboratory ☐ Imaging/Radiology ☐ Nursing Notes ☐ Medication Record		☐ Demographics ☐ Rehabilitation Services ☐ Special Test/Therapy ☐ Itemized Bill/Claims ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not, applicable, check here ☐

I understand that:

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
5. I will receive a copy of this form after I sign it.

Patient Signature

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient: