community health centers

Community Health Centers, Inc.
(407) 905-8827 (352) 314-7400
WWW.CHCFL.ORG
Fax: (321) 221-2048

Authorization to Disclose Health Information

I, the undersigned, authorize: Community Health Centers, 110 S Woodland St, Winter Garden, FL 34787 to release my health information as noted below. Patient Directive Fees vary based on page counts and delivery methods.

1) Patient Information:

Name of Patient (Type/Print) | Other Names Used | Date of Birth | Phone Number

Address | City | State | Zip

2) Release Information To:

Name / Facility | Attention | Phone Number | Fax Number

Address | City | State | Zip

3) Purpose of Request:

☐ Personal ☐ Legal ☐ Disability ☐ Other: _____
☐ Treatment ☐ Insurance ☐ Transfer/Reason:_____

Charges outlined below will be applied for all copies released directly to the patient and other entities. The charge does not apply when the records are sent directly to a healthcare provider for ongoing treatment purposes.

4) Choose Record Date Range (check only 1 box)

☐ Provide all medical records for the previous two-year period (medical history, progress notes, lab reports, and diagnostic testing).
☐ Requested dates of service: _____. Other documents from medical record: _____.

5) Choose Delivery Method

☐ Sent securely (electronically). Email Address: _____
☐ Sent by mail.
☐ Sent on a CD.

6) Payment Options:

CHECK: Make checks payable to SHARECARE.
CREDIT CARD: An invoice will be sent to your email address. If you do not have email, an invoice will be sent to your mailing address.

7) Authorization to Release Sensitive Information:

Check the boxes below indicating how sensitive information should be handled even if the categories do not necessarily apply.

CHECK AND INITAL EACH LINE		**INITIAL EACH LINE**
I ☐ **DO**	☐ **DO NOT** want information about ***Mental Health** released	_____
I ☐ **DO**	☐ **DO NOT** want information about ***HIV Tests & Related Information** released	_____
I ☐ **DO**	☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released	_____
I ☐ **DO**	☐ **DO NOT** want information about ***Sexually Transmitted Disease** released	_____
I ☐ **DO**	☐ **DO NOT** want information about ***Genetic Diseases/Tests DNA** released	_____
I ☐ **DO**	☐ **DO NOT** want information about _____ released	_____

STOP Please confirm that you have put a **checkmark and initialed** all the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfil this request.

Patient's Signature **Date**
(Required for all patients 18 years and older. 18 years and older for psychiatric records)

Parent of Legal Guardian Signature **Date**
(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

This authorization will expire 90 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the clinic took before it received the revocation. I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard. I understand that my treatment or continued treatment by the clinic and its affiliates is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it. 42 CFR part 2 prohibits unauthorized disclosure of these records. I understand that I may inspect or copy the information that is used or disclosed.