Consent to Release Patient Health Information to

Individuals Santa Cruz Community Health Centers P.O. Box 542
Santa Cruz, CA 95060
Fax: 831-457-2486

REV 5/22

Patient Information

Patient Full Name:_____ Date of Birth: _____/_____/_____

Patient Address: _____ Home Phone: (_____) _____--_____

City : _____State: _____ Zip: _____ Work Phone: (_____) _____--_____

Release Information

To

I herby authorize Santa Cruz Community Health Centers to release my personal health information to the individual(s) listed below verbally and in writing.

[ ] Information is not to be released to anyone.

1. Name: _____ Telephone Number: (_____) _____--_____	[ ] Spouse/Partner [ ] Parent [ ] Child [ ] Sibling [ ] Other: _____	[ ] All Records [ ] Picking up medical forms, orders, and written prescriptions [ ] Scheduling, confirming, and cancelling appointments [ ] Other: _____
2. Name: _____ Telephone Number: (_____) _____--_____	[ ] Spouse/Partner [ ] Parent [ ] Child [ ] Sibling [ ] Other: _____	[ ] All Records [ ] Picking up medical forms, orders, and written prescriptions [ ] Scheduling, confirming, and cancelling appointments [ ] Other: _____
3. Name: _____ Telephone Number: (_____) _____--_____	[ ] Spouse/Partner [ ] Parent [ ] Child [ ] Sibling [ ] Other: _____	[ ] All Records [ ] Picking up medical forms, orders, and written prescriptions [ ] Scheduling, confirming, and cancelling appointments [ ] Other: _____

*This Authorization is valid indefinitely unless you specify otherwise (enter expiration date) _____. You may revoke this Authorization at any time by providing a written statement, except to the extent that the provider has already completed action on it. ** If you are the legally recognized representative of the patient you must provide supporting documentation.

_____ _____
Patient Signature **Date***

_____ _____
Parent/Legally Recognized Representative Signature** **Date****

Relationship: _____

Office Use
Verified by:
_____