At Santa Cruz Community Health (SCCH), we want you to feel safe and at home. Your health information is private.

Release of Information Form

At SCCH, we cannot share your medical records with anyone unless you say it is okay with you. When you sign this form, it means the people listed here can see or hear that information. You can even tell us who you do NOT want to have these records.

Name: _____
[Print the patient's name here.]

Address:_____
[Print the address of the patient here.]

City: _____State: _____ Zip Code: _____

Date of Birth: ____/____/_____ Home Phone: (___) _____

Work Phone: (___) _____ Cell Phone (___) _____

Person #1 - I authorize SCCH to give my health records to:

Name: _____

Phone number: (___) _____

Please check the boxes that are true for you. This person is my:

- ❑ Spouse or Partner
- ❑ Parent
- ❑ Child
- ❑ Brother or Sister
- ❑ Other _____

This person can:

- ❑ See all my records.
- ❑ Talk to my health care providers.
- ❑ Pick up my medical forms, orders, and written prescriptions.
- ❑ Set up visits for me.
- ❑ Confirm or cancel my visits for me.
- ❑ See these health care records only: _____

Person #2 - I authorize SCCH to give my health records to:

Name: _____

Phone number: (___) _____

Please check the boxes that are true for you. This person is my:

- ❑ Spouse or Partner

- ❑ Parent
- ❑ Child
- ❑ Brother or Sister
- ❑ Other _____

This person can:

- ❑ See all my records.
- ❑ Talk to my health care providers.
- ❑ Pick up my medical forms, orders, and written prescriptions.
- ❑ Set up visits for me.
- ❑ Confirm or cancel my visits for me.
- ❑ See these health care records only: _____

Person #3: It is NOT okay for us to give your health information to:

Name: _____

Phone number: (___) _____

Please check the box that is true for you. This person is my:

- ❑ Spouse or Partner
- ❑ Parent
- ❑ Child
- ❑ Brother or Sister
- ❑ Other: _____

When you sign this form, it means that you understand that:

1. This form can last forever unless you tell us it should end on this date _____.
2. You can change your mind any time. You just need to give us a written statement that says what has changed.
3. We cannot take back records that have already been shared
4. If you can legally sign for the patient, you must give us papers that show that.

_____ Date: _____
Sign here if you are the patient.

_____ Date: _____
Sign here if you are the parent or representative.

_____
Print here how you are related.