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

Release of Records Form: Releasing Records

At SCCH, we cannot share your medical records with anyone unless you say it is okay with you. You may want your own records, or you may want us to send your records to another agency. If you sign this form, it means it is okay with you to release your 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 (___) _____

I authorize SCCH to give me my medical records in the following way:

- ❑ I will pick up my records at:
  - __Live Oak Health Center
  - __Santa Cruz Mountain Health Center
  - __Santa Cruz Women's Health Center
- ❑ Please mail my records to the address listed above.
- ❑ Please mail my records to this address:
  _____
  City: _____ State: ____ Zip: _____
- ❑ Please fax my records to (___) _____

I authorize SCCH to send my health records to this agency:

Agency Name: _____

Address: _____

City: _____ State: _____ Zip: _____
Phone number: (___) _____ Fax Number: (____) _____

Why do you want to share your records? Check the boxes that are true for you.

- ❑ I need the records for personal reasons.
- ❑ It helps me get the health care I need.
- ❑ There are legal reasons.
- ❑ I need to share the records for insurance.
- ❑ There are other reasons: _____

Here is the date range of the records to be shared:
Start Date: _____ End date: _____

Here are the parts of the records that can be shared:

- ❑ My entire health record
- ❑ Lab reports
- ❑ Other: _____
- ❑ Vaccines
- ❑ Billing

Some kinds of records are personal. Please check those records you want to be shared. Then sign with your initials. **Initials**

- ❑ Mental Health Records _____
- ❑ HIV / AIDS tests, results, and treatment _____
- ❑ STI tests, results, and treatment _____
- ❑ Alcohol and Substance Abuse treatment _____
- ❑ Genetic Testing _____
- ❑ Other:_____ _____

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

1. This form is good for one year, 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 you no longer give your okay to share your records.
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.
5. Your records may not be protected by HIPAA if you or another agency shares your records. But California law prevents anyone who gets your records from sharing them without your written okay.
6. Your health care benefits can't be affected by whether or not you sign this form.

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

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

_____
Print here how you are related.