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

Release of Records Form: Requesting Records

At SCCH, we cannot share your medical records with anyone unless you say it is okay with you. Sometimes, another agency may need to give us your records so we can give you the care you need. If you sign this form, it means that it is okay with you for another agency to share your records with SCCH.

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 give permission for SCCH to get my health records from:

Agency Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone number: (___) _____ Fax Number: (____) _____

By signing this form, I understand that:

1. This form is good for one year, unless you tell us it should end on this date: _____
2. I can change my mind any time. I just need to give SCCH a written statement that says I no longer give my 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. My records may not be protected by HIPAA if I or another agency shares my records. California law prevents anyone who gets my records from sharing them without my written okay.
6. My health care benefits can't be affected by whether or not I 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.