



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 7/17

Patient Information

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

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

City: _____ State: _____ Zip: _____ Work Phone: (____) ____--____

Release Information To

I hereby 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.

<p>1. Name: _____</p> <p>Telephone Number: (____) ____--____</p>	<p><input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Other: _____</p>	<p><input type="checkbox"/> All Records</p> <p><input type="checkbox"/> Picking up medical forms, orders, and written prescriptions</p> <p><input type="checkbox"/> Scheduling, confirming, and cancelling appointments</p> <p><input type="checkbox"/> Other: _____</p>
<p>2. Name: _____</p> <p>Telephone Number: (____) ____--____</p>	<p><input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Other: _____</p>	<p><input type="checkbox"/> All Records</p> <p><input type="checkbox"/> Picking up medical forms, orders, and written prescriptions</p> <p><input type="checkbox"/> Scheduling, confirming, and cancelling appointments</p> <p><input type="checkbox"/> Other: _____</p>
<p>3. Name: _____</p> <p>Telephone Number: (____) ____--____</p>	<p><input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Other: _____</p>	<p><input type="checkbox"/> All Records</p> <p><input type="checkbox"/> Picking up medical forms, orders, and written prescriptions</p> <p><input type="checkbox"/> Scheduling, confirming, and cancelling appointments</p> <p><input type="checkbox"/> Other: _____</p>

*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: _____
