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 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:
_____