Access Community Health Center

520 N. Main St. Suite 120 Santa Ana CA. 92701

14642 Newport Ave Suite 101, Tustin CA. 92780

24953 Paseo De Valencia, Suite 7C. Laguna Hills CA 92653

Phone: 714-352-5800 **Fax**: 714-352-5801

Medical Records Release & Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ **Date of Birth**: _____**Contact Number**: _____

I, _____ hereby authorize: (previous Physician's name, Hospital etc.) __Access Community Health Center_ Contact Number: _714-352-5800 Fax: 714-352-5801___

to provide my medical record the information specified below to:

Medical Group, Physician, Hospital, Etc. _____

Address: _____

Phone: _____ Fax: _____

Information to be released:

*Progress notes *X-ray reports *Demographics *Consultation Reports

*Medication Reconciliation form *Hospital Records *Problem

List*Operative Reports *Patient Health Questionnaire *ECGs *Laboratory Test

*Other: _____

*Note, if any of these records contain any information from previous providers or information about HIV/AIDs status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

Unless otherwise revoked, this authorization expires on_____, (*date*). If no date is indicated, the Authorization will expire 12 months after the date of signing this form.

You are entitled to receive a copy of this authorization.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy law. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by the law. By signing below I represent and warrant that I have authority to sign this document and authorize the use and disclosure of the protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Name of Patient or Representative Date

_____

Signature of Patient or Patients Representative