COMMUNITYCARE™
HEALTH CENTERS

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize CommUnityCare to *release/obtain* (circle one) **medical information concerning:** **Please print clearly in all fields.**

Patient Name: _____ SS No. XXX-XX-_____ MR# _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Email address_____

This information is to be *released to/obtained from* (circle one)**:**

Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Fax or Email:

Return address for CommUnityCare Health Center:

_____

_____

_____

Please release the following information, indicated by an "X" *(Mark all that apply)*:

Service Dates From _____to _____

__Abstract (2 yrs. Of records)
__Office visit/progress notes
__Imaging
__Labs
__Diagnostics
__Immunizations
__Medication List
__Dental Records
__Dental X-Rays
__ Billing
__Other _____

Your initials are required if you would like to release the following sensitive Information:

	INITIAL
HIV/ Test & Information	_____
Mental Health records	_____
MAT/Alcohol/Substance records	_____
Genetic Testing Information	_____

This information is necessary for the following purposes:

___Follow-up Care ____ Personal ___Disability Benefits ___ Legal _____Other please Explain_____

Release my information by:

_____Mail _____Pick up at _____ Clinic Name _____ MyChart Format**:** _____ Paper

____CD/Electronic _____Fax Fax No: _____ Given to patient by_____@ clinic. ____ROI to file

The patient or the patient's representative must read the following statements:

I, the undersigned, understand that this authorization is valid until the earlier of my death, reaching the age of majority, permission is withdrawn, or the following specific date Month_____ Day_____ Year_____. If I withdraw permission, I understand that I must complete the revocation authorization form in writing. I understand that the provision of my health care and the payment for my health care will not be affected if I do not sign this form. Upon expiration, CommUnityCare can no longer use or disclose my information for the above purposes without a new authorization.

DISCLOSURE STATEMENT RELATED TO MEDICAL ASSISTED THERAPY RECORDS

This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except at provided at §§2.12(c)(5) and 2.65.

SIGNATURE of Patient or Authorized Party Todays Date **RELATIONSHIP** to Patient

WITNESS_____ **REASON** Patient is not signing _____