SHINGLE SPRINGS Health & Wellness Center Healthcare for All

SHINGLE SPRINGS HEALTH & WELLNESS CENTER

SHINGLE SPRINGS HEALTH AND WELLNESS
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Complete all sections, date and sign:

1. **I, (Name of Patient): _____ DOB: _____,**
   Telephone: (__) _____hereby authorize the disclosure of information from my record.

2. **The information is to be DISCLOSED BY:**
   Name of Person/Organization/Facility: Shingle Springs Health and Wellness Center
   Address: 5168 Honpie Road
   City: Placerville State: Ca Zip: 95667
   Telephone: (530) 387-4975 Fax: (530) 672-1507

   And is to be PROVIDED TO:
   Name of Facility: _____
   Address: _____
   City: _____ State:_____ Zip: _____
   Telephone: _____ Fax: _____

3. **The purpose of this disclosure is:**
   _____

4. **The information to be disclosed from my health record: (check appropriate box(es):**
   _____ Entire record
   _____ Only information related to event/illness (specify) _____
   _____ Only the period of events from: _____ to: _____
   _____ Other (specify): _____
   _____ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-Patient privilege)

   If you would like any of the following sensitive information disclosed, check the applicable box (es) below.
   _____ Alcohol/Drug Abuse Treatment/Referral _____ HIV/AIDS- related treatment
   _____ Sexually Transmitted Disease _____ Mental Health (other than psychotherapy notes)

5. **I understand that I may revoke this authorization in writing submitted at any time to the Health Records Department, except to the extent that action has been taken in reliance on this authorization, or if this authorization was obtained as a condition of providing insurance coverage, other law provides the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date. Expiration Date: _____**

   I understand that SSTHP will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

   I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may not longer be protected by the Health Insurance portability and Accountability Act (HIPAA) (45CFR Par164), and the privacy Act of 1975 (5usc 552a).

_____ _____ _____
Signature of Patient or Authorized Representative Relationship to patient Date

Office use only

Notes:

Incomplete:_____

Complete:_____

Faxed:_____

Received:_____