



County of Santa Cruz Health Services Agency

AUTHORIZATION TO RELEASE MEDICAL RECORDS

The County of Santa Cruz Health Services Agency believes strongly in your right and your family's right to privacy and confidentiality as this relates to medical information that we may gather, maintain, or use in the course of providing health services. This is referred to as Protected Health Information (PHI).

How do we typically use or share your PHI without Your Written Authorization?

During registration of your first visit you are asked to sign a treatment consent form before you receive treatment. This allows Health Services Agency to provide medical treatment to you or your dependent. The following categories describe examples of the way we use and disclose PHI:

Treatment

- We may use and disclose your PHI to provide, coordinate, or manage your health care

Payment / Billing

- Your PHI will be used, as needed, to obtain payment for your health care services

Healthcare Operations

- We may use or disclose PHI to support the necessary activities of the Health Services Agency

Uses and Disclosures of PHI Based upon Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization, unless permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent the Health Services Agency has already disclosed your PHI as indicated in the authorization, or the authorization was obtained as a condition of obtaining insurance coverage.

The below Authorization to Release Medical Information Form is required to permit the County of Santa Cruz Health Services Agency to release your medical records to the person or organization of your selection. Please use the below addresses when completing the *Hereby authorize* section of the form. The *To furnish to* section is who or where you want your medical information provided to. Please FAX the completed form to the appropriate number listed at the top of the authorization form.

Santa Cruz Health Center
1080 Emeline Ave, Santa Cruz

Homeless Persons Health Project (HPHP)
115-A Coral St., Santa Cruz

Watsonville Health Center
1430 Freedom Blvd, Suite D., Watsonville

Please refer to the [Notice of Privacy Practices](#) for a full description of your right to privacy.

County of Santa Cruz



HEALTH SERVICES AGENCY OUTPATIENT MEDICAL CLINICS DIVISION

SANTA CRUZ HEALTH CENTER
(831) 454-4100 FAX (831) 454-4296

WATSONVILLE HEALTH CENTER
(831) 763-8400 FAX (831) 763-8237

HPHP
(831)454-2080 FAX (831) 454-2434

TDD: (831) 454-4123

AUTHORIZATION TO RELEASE INFORMATION FROM MEDICAL RECORDS

I, _____

Hereby authorize

To furnish to

(name and address of person or organization)

(name and address of person or organization)

any and all records obtained in the course of my diagnosis and treatment, which pertain to and may include the mention of alcohol and/or drug abuse, psychiatric illness, HIV+, AIDS Related Complex (ARC), and/or Acquired Immune Deficiency Syndrome (AIDS), concerning:

(patient's name)

(patient's social security number)

(patient's date of birth)

(patient's medical record number)

The disclosure of records is required for the following purposes: _____

The disclosure shall be limited to the following specific types of information: _____

This consent shall expire: _____
(date)

I understand I have a right to receive a copy of this authorization upon my request.

Copy requested and received: Yes _____ No _____ Initials _____

A copy of this consent is just as valid as an original.

Patient signature

(date)

Witness name and title

Parent, guardian or authorized representative of patient

PROHIBITION ON REDISCLOSURE: This information is being disclosed to you from records which confidentiality is protected by federal law. Federal regulations (42CFR part 2) prohibit you from making any further disclosure of this information except with a specific written consent of the person to whom it pertains.