CONTRA COSTA HEALTH SERVICES
CONTRA COSTA REGIONAL MEDICAL CENTER AND HEALTH CENTERS

AUTHORIZATION FOR CONTRA COSTA HEALTH SERVICES (CCHS) TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION (PLEASE PRINT)			
FIRST NAME	MIDDLE INITIAL	LAST NAME	
OTHER NAME AT TIME OF TREATMENT (IF DIFFERENT THAN ABOVE)			
DATE OF BIRTH (MM/DD/YEAR)			
STREET ADDRESS	CITY	STATE	ZIP
PHONE NUMBERS			
HOME	MOBILE	WORK	
PLEASE CHECK PREFERRED PHONE FOR CONTACT/MESSAGES: ☐ HOME ☐ MOBILE ☐ WORK			

I am the ☐ Patient ☐ Parent/Guardian ☐ Conservator ☐ Other ____________________
and hereby authorize Contra Costa Health Services (CCHS) to use or disclose health information of the above-named individual to:

SEND/DELIVER RECORDS TO ☐ SAME AS ABOVE ☐ OTHER NOTED BELOW			
NAME OF PERSON, ORGANIZATION, AGENCY			
STREET ADDRESS	CITY	STATE	ZIP
PHONE NUMBER	FAX NUMBER		
PURPOSE: ☐ PERSONAL USE (AB610) ☐ FORM ☐ OUTSIDE HEALTH CARE PROVIDER ☐ OTHER: ____________________			

WHAT RECORDS DO YOU WANT?
DATE(S) OF TREATMENT: ______/______/______ THROUGH ______/______/______
INPATIENT: ☐ STANDARD (INCLUDES DOCTOR ASSESSMENTS AND REPORTS, PROGRESS NOTES, TEST RESULTS, MEDICATION) ☐ ENTIRE (INCLUDES STANDARD PLUS FLOW SHEETS, NURSING NOTES, ETC.) ☐ ADDITIONAL (PLEASE DESCRIBE) ____________________
OUTPATIENT: ☐ CLINIC VISIT NOTE(S) ☐ TEST RESULT(S): TYPE: ____________________ ☐ ED OR PES VISIT(S) ☐ SURGERY/PROCEDURE REPORT: ____________________ ☐ LETTER REPRINT: DATE(S): ____________________ ☐ LIST OF VISITS ☐ OTHER: ____________________

THE SOURCING GROUP 800-789-6594

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HOW WOULD YOU LIKE THE RECORDS PREPARED? ☐ PAPER ☐ DIGITAL (CD/DVD) ☐ Release to MyccLink

HOW WOULD YOU LIKE THE RECORDS DELIVERED WHEN THEY ARE FOR YOURSELF?
☐ DELIVERY BY US MAIL ☐ I WILL PICK THEM UP ☐ I WILL PAY FOR CERTIFIED US MAIL ☐ Release to MyccLink

INFORMATION TO BE RELEASED: This is a **full disclosure** authorization of health care information which includes health care maintenance records, and medical, surgical, sexually-transmitted disease, mental health, alcohol or other drug abuse care and treatment records, if any. This consent also authorizes the disclosure of HIV test results, if any. ***Your initial below indicates you understand and agree.***

_______ **NO** Exclusions
INITIAL

Please initial below to indicate any records you do not want released in this request:

_____________ Exclude HIV test results
INITIAL

_____________ Exclude Substance Abuse treatment information
INITIAL

_____________ Exclude Behavioral Health treatment information
INITIAL

_____________ Exclude other (Specify):____
INITIAL

RE-DISCLOSURE: If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected.

This authorization is effective immediately and will remain in effect for one (1) year or until _________________ (date or event). I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the address where I received care. My revocation will be effective upon receipt, but will not be effective to the extent that CCHS has acted in reliance upon this Authorization. I have a right to receive a copy of this Authorization. If I am being asked by CCHS to authorize this disclosure, I have a right to inspect or obtain a copy of such health information disclosed. I may refuse to sign this Authorization. Neither treatment, payment, enrollment or eligibility of benefits will be conditioned on my providing or refusing to provide this Authorization.

SIGNATURES	
DATE	PATIENT SIGNATURE
AUTHORIZED SIGNATURE (IF OTHER THAN PATIENT)	RELATIONSHIP
SIGNATURE OF HOSPITAL STAFF WHEN REQUIRED	
EMPLOYEE NAME	DATE