CHAPA-DE INDIAN HEALTH

***Grass Valley Health Center*** 1350 E. Main St., Grass Valley CA 95945
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# Release of Information Form

| | | | |
|---|---|---|---|
| **1** | **Patient's Last** | **Patient's First** | **Date of Birth** |
| **2** | ☐ Please send records from Chapa-De (To Person/Facility Below) *Processed within 15 days | ☐ Please release records to Chapa-De (From Person/Facility Below) | |
| **3** | **Full Name of Organization/Provider/Individual (or Self)** | | |
| | **Address** | | **City** |
| | **State** | **Zip** | **Phone number starting with area code** |
| | **Send to:** ☐ Mail ☐ Email: | | ☐ Fax: |
| **4** | **CHOOSE ONLY ONE (1) Per Release**<br>____ Medical ____ HIV/AIDS Testing/Treatment ____ Alcohol/Drug Use Treatment<br>____ Dental ____ Behavioral Health ____ Optometry | | |
| **5** | **Time Frame:** ☐ Last Visit ☐ Past Year ☐ All ☐ Specific Date Range: | | |
| **6** | ☐ Progress Notes ☐ Last Physical ☐ Medication List ☐ Immunization Records ☐ EKG Reports<br>☐ Consult Reports ☐ Radiology Reports ☐ Lab Reports ☐ Charges/Payments ☐ Dental X-rays<br>☐ All records of visits ☐ Other (Specify) _____. | | |
| **7** | **Reason for release:** ☐ Personal ☐ Transfer of Care ☐ Other _____ | | |
| **Authorization** | By signing, I authorize use/disclosure of my health information and understand that:<br>▪ I may revoke this authorization at any time by contacting Chapa-De in writing.<br>▪ This authorization is valid for 1 year maximum or this earlier date: ___/___/____.<br>▪ The recipient of your health information may not further disclose your information without obtaining another authorization from you.<br>▪ All Alcohol & Substance abuse health information is protected and only releasable with a separate express written consent of the person it pertains to.<br>▪ My treatment/eligibility of care is not based on this authorization.<br>▪ This authorization is voluntary and a photocopy or fax of this authorization is as valid as the original.<br>▪ I have the right to a copy of this authorization. | | |

**SECTIONS 1-7 MUST BE COMPLETED TO BE VALID**

**Signature**

✘_____Date:____/____/_____Tel:(____) _____-_____

**If not patient:** ☐ Patient's Representative (State Relationship )

Internal Use Only: ☐ Completed ___/___/____ By:✘_____ MRN _____