Pit River Health Service Inc
Medical/Dental/Behavioral Health Clinics
36977 Park Ave Burney CA 96013
(530)-335-3651
Release of Information

PLEASE FAX ALL COPIES TO PRHS MEDICAL RECORDS (530)335-3221

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____Date of Birth:_____

Address:_____Phone:_____

City: _____ State: _____ Zip: _____

I hereby authorize: _____

Address:_____Phone: _____

To disclose my protected health information listed below to: (clinic/hospital, person, etc.)

Name:_____

Address: _____

City:_____State:_____Zip:_____

Phone:_____Fax:_____

INFORMATION TO BE RELEASED

Dates of service: _____to_____

- ☐ History and physical exam
- ☐ Lab report
- ☐ X-ray report
- ☐ Consultation report
- ☐ Behavioral Health/Psych Must Initial: _____
- ☐ Other_____

PURPOSE OF DISCLOSURE:

- ☐ Changing physicians
- ☐ Second Opinion
- ☐ Continuing Care
- ☐ At patient request
- ☐ Workers' Comp
- ☐ Legal
- ☐ Insurance
- ☐ School
- ☐ Other_____

1. I understand that this authorization will expire two years from my last date of service. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying the Privacy Officer, in writing, at Pit River Health Service, Inc. and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care will not be affected if I do not sign this form. My PRC and/or 3rd party funds can be affected if I choose not to sign this form.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
6. I request that the records identified above be handled in the following manner:
   ☐ Mail to Address Listed Above ☐ I will pick ☐ Fax#above/Attn to:_____
   ☐ A Representative will pick-up on my behalf. (Valid ID is required) Representative Name:_____ DOB:_____
7. I understand that I will get a copy of this form after I sign it upon request.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____ OR _____ _____

Signature of Patient **Date** **Parent/Legal Guardian/Authorized Person** **Date**

_____

Relationship to Patient

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Please note: The Information contained in this report may be privileged, confidential and protected from disclosure. If the reader of this is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited by law. If you have received this communication in error, please notify the sender immediately and destroy his copy. Call 530-335-0323 if you have received this in error.

For Office Use Only

Date Request Filled _____ By_____, _____
Printed Name Title

Identification Presented: ☐ yes ☐ no _____ RPMS Account #:_____
Type of Identification

Date of Release_____ ,See line 6 IF PICKED UP Signature required _____

HIM Signature_____

MRN:_____ PRHS MR05/2018