Authorization to Obtain Health Records

The County of Sacramento, Primary Care Center, is requesting the records for the following client.

☐ Mail: Primary Care Center, 4600 Broadway, Suite 1100, Sacramento, CA 95820.

☐ Fax: (916) 874-9670,

If you have any questions please feel free to contact us at (916) 874-9670

Records and Information Pertaining To	**DATE:**	**RECORD #:**
LAST NAME:	**FIRST NAME:**	**MIDDLE INITIAL:**
SSN or ID:	**DATE OF BIRTH:**	
ADDRESS:		

Check mark the types of confidential information to be obtained

☐ Entire Record (Excludes HIV, Mental Health & Alcohol/Drug Info)	☐ Lab Tests	☐ Attendance Only Records
☐ Include HIV or AIDS Information	☐ Medication	☐ Consultation Reports/ Physician Orders
☐ Include Alcohol/Drug Information	☐ Treatment/ Personal Service Plan	☐ Progress Report/Notes
☐ Include Mental Health Information	☐ Discharge Summary	☐ Psychiatric/Psychological Assessment/Testing Results
☐ Medical Records relating to	☐ Social History	☐ Billing or Payment Information
☐ Records from a specific visit or hospitalization (enter date and location)		
☐ Other		

Authorization will expire on _____ date.

Specifically write the purpose(s) for obtaining this confidential health information

Enter the Program, agency or office in which you want to obtain medical records from (If more than one see Attachment A)

PROGRAM/AGENCY/OFFICE NAME:		
ADDRESS:	CITY/STATE:	ZIP CODE:

CONTACT NAME:	TELEPHONE #:	FAX #:

Important Note

Special kinds of health information have specific laws and rules that have to be followed before that information can be disclosed.

HIV, Alcohol and Drug, and Mental Health Treatment: These records are protected under federal or state law and cannot be disclosed without your written authorization unless otherwise provided. Re-disclosure of these records is not allowed, except in compliance with state or federal law or with your written permission. All HIV test information released must be labeled with a statement that: "This information may not be disclosed to anyone without the specific written authorization of the individual."

I understand that my representative or I may revoke this authorization to obtain, use and disclose my information at any time in writing. I understand this change will not affect information that has already been shared. I understand that this authorization is voluntary; that my health information may be protected under federal or state confidentiality laws. I understand that I may choose not to sign this authorization and this will not affect my ability to obtain treatment or payment or my current eligibility for health care benefits. However, if this information is necessary to determine if I am eligible to enroll in the Sacramento County Health program, I may not be able to show I qualify for these services.

(If applicable) I understand that County of Sacramento has been asked to provide a health care service to me (such as a test or evaluation) only for the purpose of being able to provide that information to someone else, and if I choose not to authorize the disclosure of that information to the other person, then County of Sacramento may not provide that health service to me.

Full Legal Signature or Mark of Individual **Date**

Full Legal Signature of Representative **Relationship** **Date**

Signature of County Representative **Date**

If the signer is a guardian or legal custodian of an adult, minor, emancipated minor or a representative of a deceased patient and is authorized by state law to act on behalf of the individual in making decisions about health care, a copy of the legal authority (guardianship or custody order) must be attached to this form. If the signer is a personal representative that does not have the legal authority, the client must provide documentation in writing appointing this person as a representative and this documentation must be attached.

Attachment A

For obtaining from more than one Program/Agency/Office:

Enter who you want us to obtain your health information from:

PROGRAM/AGENCY/OFFICE NAME:		
ADDRESS:		
TELEPHONE NUMBER:	**FAX NUMBER:**	**CONTACT NAME (IF KNOWN):**

PROGRAM/AGENCY/OFFICE NAME:		
ADDRESS:		
TELEPHONE NUMBER:	**FAX NUMBER:**	**CONTACT NAME (IF KNOWN):**

PROGRAM/AGENCY/OFFICE NAME:		
ADDRESS:		
TELEPHONE NUMBER:	**FAX NUMBER:**	**CONTACT NAME (IF KNOWN):**

I agree that the County may request my health information as Indicated above to the Program/Agency/Offices indicated in this Authorization:

Full Legal Signature or Mark of Individual **Date**

Full Legal Signature of Representative **Relationship** **Date**

Signature of County Representative **Date**

Authorized Agent:
Knox Attorney Service, Inc./ Knox Services LLC.