ROI | Health Information Management Department
160 E. Virginia St. Suite 280 San Jose, CA 95112
Phone: (408) 579-6112 Fax: (408) 579-6139
medicalrecords@gfhn.org

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Gardner Health Services (GHS) requires Authorization for the Release of Patient Health Information. Completion of this form validates authorization in compliance with California and Federal Law, but does not condition treatment, payment, enrollment, or eligibility for benefits. Please read this form carefully and complete all sections as incomplete forms will not be processed & returned. Photo ID verification is also required for all requests. Once recieved, your request will be sent to our copy service Verisma & processed within 5-7 business days. To follow-up on your request status, please contact Verisma at: 1 (866) 442-9026.

PATIENT INFORMATION

Patient Name: _____ (First) _____ (M.) _____ (Last)

Date of Birth: _____ (Month) / _____ (Day) / _____ (Year) Phone #: _____

Medical Record Number: _____ ☐ I am the Patient. (Self-Request)

REQUEST INFORMATION FROM

Select the Gardner Health Center(s) below or Provide Other Information for Outgoing ROI Request:

- ☐ Alviso Health Center: 1621 Gold Street, San Jose, CA 95002
- ☐ Compre Care Health Center: 3030 Alum Rock Avenue, San Jose, CA 95127
- ☐ Gardner Downtown Health Center: 725 E. Santa Clara Street, San Jose, CA 95112
- ☐ Gardner Health Center: 195 E. Virginia Street, San Jose, CA 95112
- ☐ Gardner Packard-Children's Health Center: 3350 El Camino Real, Ste 100, Atherton, CA 94027
- ☐ Healthcare For the Homeless: 195 E. San Fernando St., Ste. 100 San Jose, CA 95112
- ☐ Proyecto Primavera: 160 East. Virginia Street, Suite 100, San Jose, CA 95112
- ☐ South County Health Center: 7526 Monterey Road, Gilroy, CA 95020
- ☐ Specialty Service Center: 160 East. Virginia Street, Ste. 280, San Jose, CA 95112 ***Mental Health**
- ☐ St. James Health Center: 55 East. Julian Street, San Jose, CA 95112

Clinician Name *(Required for Specialty):* _____

☐ Other *(Outgoing):* _____
Name | Address (Street, City, State, Zip Code) | Phone | Fax

RELEASE INFORMATION TO

Requested By: _____ (Name of Person / Organization) _____ (Relationship To Patient)

_____ (Street Address) _____ (City) _____ (State) _____ (Zip Code)

_____ (Phone Number) _____ (Fax Number) _____ (Email Address)

☐ **Self-Review:** Patient is requesting to review their records with their clinician on site.

Delivery Method: ☐ Mail ☐ Fax ☐ Other _____

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PURPOSE OF USE

This disclosure of information is being requested for the following:

- ☐ Continuation of Care
- ☐ DACA / INS
- ☐ Disabilty Claim
- ☐ Evaluation / Review
- ☐ Insurance / Payment
- ☐ Legal / Court
- ☐ Personal Use
- ☐ Research Study
- ☐ School Enrollment
- ☐ Transfer of Records
- ☐ Other _____

INFORMATION TO BE RELEASED

Select the protected health information (PHI) to be released and provide the Dates of Treatment:

- ☐ Billing Records
- ☐ Cardiology (EKG)
- ☐ Chiropractic Records
- ☐ COVID-19 Results
- ☐ Dental Records
- ☐ Entire Record
- ☐ Immunization Record
- ☐ Lab Results
- ☐ Medication List
- ☐ OBGYN / Prenatal
- ☐ Optometry Record
- ☐ Physical (H&P)
- ☐ Podiatry Record
- ☐ Radiology Report
- ☐ Other _____

Specific Authorization is required to release the following sensitive information per California and Federal law pursuant to 42 CFR Part 2. Patient must initial separately for the release of:

Communicable Disease Results _____ Genetic Testing Results _____ HIV / AIDS Records _____

Specialty Mental Health: *(excludes Psychotherapy Notes)* _____ Substance / Drug Abuse Records _____

DATES OF TREATMENT: _____ - _____
From (Start Date) To (End Date)

Limitations of this Disclosure: _____

YOUR RIGHTS

Gardner Health Services (GHS) may not condition treatment, payment, enrollment, or eligibilty for benefits based on this authorization. Refusal to sign this authorization form will not affect your eligibilty to obtain treatment. This authorization to release patient health information is voluntary. You are entitled to recieve a copy of this authorization upon request.

DURATION: Authorization shall remain in effect for 12 months from the signature date unless revoked.

REVOCATION: You have the right to revoke this Authorization at any time. The revocation must be in writing, signed by you or your representative, and delivered to: ATTN: HIM Department, Gardner Health Services, 160 East Virginia Street Suite 280, San Jose, CA 95112. The revocation will take effect when Gardner Health Services receives it, except to the extent GHS or others have already relied on it.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me, or unless such use or disclosure is specifically required or permitted by law.

SIGNATURE

_____ _____ _____
Date Print Full Name Signature

Clinical Staff Use Only - Please complete the following before sending ROI to Right Fax:

Clinic: _____ Reviewed By: _____ Photo ID Verified? ☐ Fax Completed? (Outgoing) ☐