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

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Gardner Health Services (GHS) requires authorization for the release of patient health information. Completing this form validates authorization in compliance with state 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 and will be returned.** Photo ID verification is also required for all requests. Once received, your request should be processed within 15-30 calendar days. To check the status of your request please call GHS Health Information Management Department at (408) 579-6112

PATIENT INFORMATION

Patient Name: ______________________________
First Middle Last

Date of Birth: ______________________ Phone # ( ) ____________
Month Date Year

Medical Record Number: ______________________ ☐ I am the patient (self-request)

REQUESTING INFORMATION FROM

Select the Gardner Health Center(s) below or provide other information for outgoing ROI Request:

- ☐ Alviso Health Center
- ☐ CompreCare Health Center
- ☐ Gardner Downtown Health Center
- ☐ Gardner Health Center
- ☐ Gardner Packard Children's Health Center
- ☐ South County Health Center
- ☐ St. James Health Center
- ☐ Healthcare For the Homeless
- ☐ Non-Gardner Facility (for GHS provider only) ______________________
- ☐ Proyecto Primavera Substance Use Treatment Services, Clinician Name: ______________________
- ☐ Mental/Behavioral Health Service Center, Clinician Name: ______________________
- ☐ Other Gardner Location:

____
Address (street, City, State Zip Code Phone number Fax number

RELEASE INFORMATION TO

Send to: ______________________________
Name of Person or Organization Relationship to Patient

____
Street Address City State Zip

____
Phone Number Fax Number Email Address

Choose ONE:

☐ **Delivery Method:** ☐ Mail ☐ Fax ☐ Other: ______________________
☐ **Self-Review**: Patient is requesting an appointment to review records on site with a provider

GARDNER Health Services

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PURPOSE OF USE

This disclosure of information is requested for the following purpose:

- ☐ Continuation of Care
- ☐ Insurance / Payment
- ☐ School Enrollment
- ☐ Legal / Court
- ☐ Transfer of Records
- ☐ Disability Claim
- ☐ Personal Use
- ☐ Other: ____________________
- ☐ Evaluation / Review
- ☐ Research Study

INFORMATION TO RELEASE

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

- ☐ Dental Records
- ☐ Medication List
- ☐ Optometry Record
- ☐ Podiatry Record
- ☐ Cardiology (EKG)
- ☐ Radiology Report (outside)
- ☐ Chiropractic Records
- ☐ Immunization Record (adult)
- ☐ Lab Results
- ☐ Other:
- ☐ Physical (H&P)
- ☐ Billing Records
- ☐ Entire Record

<u>Specific Authorization</u> is required to release the following sensitive information. <u>Patient/Client must initial separately for the release of:</u>

_____Communicable Disease Results
_____Genetic Testing Results
_____HIV/AIDS Records
_____Drug/Alcohol Use
_____Reproductive Health (OBGYN/Prenatal/etc.)
______Mental Health (excludes Psychotherapy Notes*)

**Requests for Psychotherapy Notes require a separate form and may not be combined with any other request*

DATES OF TREATMENT from ________________ to ________________

Limitations of this Disclosure (if any): ______________________________

YOUR RIGHTS

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

DURATION: Authorization will 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 that Gardner 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

Print Full Name: ______________________________

Signature: ______________________________ Date: ____________________

****GHS Staff Use Only ****

GHS Staff – complete the following before sending ROI to HIM RightFax

Clinic/Site: Reviewed By:

☐ Photo ID Verified ☐ Faxed to HIM (408) 579-6139