Grass Valley Health Center 1350 E. Main St., Grass Valley CA 95603
PHONE (530) 477-1727 **FAX** (530) 477-9217 **EMAIL** records@chapa-de.org

CHAPA-DE INDIAN HEALTH

Release of Information Form

1	**Patient's Last**	**Patient's First**	**Date of Birth**
2	☐ Please send records <u>from</u> Chapa-De (To Person/Facility Below) *Processed within 15 days ☐ Please release records <u>to</u> 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** ____ Medical ____ HIV/AIDS Testing/Treatment ____ Alcohol/Drug Use Treatment ____ 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 ☐ Consult Reports ☐ Radiology Reports ☐ Lab Reports ☐ Charges/Payments ☐ Dental X-rays ☐ 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: ▪ I may revoke this authorization at any time by contacting Chapa-De in writing. ▪ This authorization is valid for 1 year maximum or this earlier date: ___/___/____. ▪ The recipient of your health information may not further disclose your information without obtaining another authorization from you. ▪ All Alcohol & Substance abuse health information is protected and only releasable with a separate express written consent of the person it pertains to. ▪ My treatment/eligibility of care is not based on this authorization. ▪ This authorization is voluntary and a photocopy or fax of this authorization is as valid as the original. ▪ 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