

 _ 160 Capp St., San Francisco, CA 94110 (415) 417-3501 Fax (415) 417-3571
_ 2950 International Blvd. Oakland, CA 94601 (510)535-4400 Fax (510) 261-6438
Other:

Authorization for Release of Health Records

This request Co	oncerns health	information reg	arding the treatment o	f:	
Patient – Full Name Check one: Release of Information to Obtain Information from (Name of Physician, Hospital or Clinic)		Date of	Birth	SSN	
			-	Purpose of need for disclosure: Please include information relating to: (Initial if applicable)	
		Clinic)			
(Street Address)			AIDS or Infect	tion with HIV	
(City)	(State)	(Zip)	Psychiatric Ca		
Health informati					
Immunization	ns Patholo	gy Histo	History and Physical NotesConsultation Reports		
X-Ray Repor	t Progres	s Notes Eme	rgency Room Reports	Lab Test	
Complete Me	edical Records				
authorization understand the health care progregulations. [right to recent treatment for	was made at an at if the organic rovider, the release 45 CFR δ 164 ive a copy of the non-signing experiments on the part of the part o	ny time except to zation I have authors ased information 508 (c) (2) (iii)] In authorization cept in limited contact in the same contact in the sa	the extent that action had norized to receive the information may no longer be protected may refuse to sign this at the Native American and orditions. If this authorize	epartment that the original as been taken in reliance on it. Formation is not a health plan octed by federal privacy authorization and I have a Health Center cannot condition that a specified a different expiration	
nter if different from	n one year after	date)			
gnature of patient or parent/guardian			ntionship to patient	Date – must be included	

Created: 1/25/2017 RD

ttachments:

Prohibition on Privacy Rule 45 CFR & 164.12 (I) (2) (IV)

The Federal rules prohibit the individual or organization who receives this information from making any further disclosure unless further disclosure is expressly permitted by the written consent on the person to whom it pertains, or as otherwise permitted by 42 CFR, Part 42. 3/22/05 *lm*

Patient Health Record Request

• To request a copy of your medical record please contact _NAHC- SF_____ in person or by calling _415-417-3501__

The following information is needed to process your request

Patient Full Name

Date of Birth

Phone Number

Type of Record Requested

- All requests for patient records will be processed within 10 business days. The Native American Health Center will provide you a receipt.
- A fee may be associated with your request and will be determined on the time taken to process your request and number of pages included in your request.
- There are no charges for mailing copies of a patient health records to other health care facilities for continued health care. Please allow 10 business days to process continued care request.

If you have any questions regarding request for health care records please call the Native American Health Center Medical Records department at: 510-535-4429.

Thank you,

Native American Health Center

Oakland

 2950 International Blvd
 San Francisco

 Medical 510-535-4410
 160 Capp St

 Dental 510-535-4450
 415-417-3501

3124 International Blvd

Women Infant and Children 510-434-5300 1089 Mission St Community Wellness 415-503-1046

510-434-5421

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