



**CONTRA COSTA HEALTH SERVICES
CONTRA COSTA REGIONAL MEDICAL CENTER AND
HEALTH CENTERS**

**AUTHORIZATION FOR CONTRA COSTA
HEALTH SERVICES (CCHS) TO USE
OR DISCLOSE PROTECTED HEALTH INFORMATION**

PATIENT INFORMATION (PLEASE PRINT)			
FIRST NAME	MIDDLE INITIAL	LAST NAME	
OTHER NAME AT TIME OF TREATMENT (IF DIFFERENT THAN ABOVE)			
DATE OF BIRTH (MM/DD/YEAR)			
STREET ADDRESS	CITY	STATE	ZIP
PHONE NUMBERS			
HOME	MOBILE	WORK	
PLEASE CHECK PREFERRED PHONE FOR CONTACT/MESSAGES: <input type="checkbox"/> HOME <input type="checkbox"/> MOBILE <input type="checkbox"/> WORK			

I am the Patient Parent/Guardian Conservator Other _____
and hereby authorize Contra Costa Health Services (CCHS) to use or disclose health information of the
above-named individual to:

SEND/DELIVER RECORDS TO <input type="checkbox"/> SAME AS ABOVE <input type="checkbox"/> OTHER NOTED BELOW			
NAME OF PERSON, ORGANIZATION, AGENCY			
STREET ADDRESS	CITY	STATE	ZIP
PHONE NUMBER	FAX NUMBER		
PURPOSE: <input type="checkbox"/> PERSONAL USE (AB610) <input type="checkbox"/> FORM <input type="checkbox"/> OUTSIDE HEALTH CARE PROVIDER <input type="checkbox"/> OTHER: _____			

WHAT RECORDS DO YOU WANT?	
DATE(S) OF TREATMENT: _____/_____/_____ THROUGH _____/_____/_____	
INPATIENT:	
<input type="checkbox"/> STANDARD (INCLUDES DOCTOR ASSESSMENTS AND REPORTS, PROGRESS NOTES, TEST RESULTS, MEDICATION)	
<input type="checkbox"/> ENTIRE (INCLUDES STANDARD PLUS FLOW SHEETS, NURSING NOTES, ETC.)	
<input type="checkbox"/> ADDITIONAL (PLEASE DESCRIBE) _____	
OUTPATIENT:	
<input type="checkbox"/> CLINIC VISIT NOTE(S)	<input type="checkbox"/> TEST RESULT(S): TYPE: _____
<input type="checkbox"/> ED OR PES VISIT(S)	<input type="checkbox"/> SURGERY/PROCEDURE REPORT: _____
<input type="checkbox"/> LETTER REPRINT: DATE(S): _____	
<input type="checkbox"/> LIST OF VISITS	<input type="checkbox"/> OTHER: _____



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HOW WOULD YOU LIKE THE RECORDS PREPARED? PAPER DIGITAL (CD/DVD) Release to MyccLink

HOW WOULD YOU LIKE THE RECORDS DELIVERED WHEN THEY ARE FOR YOURSELF?

DELIVERY BY US MAIL I WILL PICK THEM UP I WILL PAY FOR CERTIFIED US MAIL Release to MyccLink

INFORMATION TO BE RELEASED: This is a **full disclosure** authorization of health care information which includes health care maintenance records, and medical, surgical, sexually-transmitted disease, mental health, alcohol or other drug abuse care and treatment records, if any. This consent also authorizes the disclosure of HIV test results, if any. ***Your initial below indicates you understand and agree.***

_____ **NO** Exclusions
INITIAL

Please initial below to indicate any records you do not want released in this request:

_____ Exclude HIV test results
INITIAL

_____ Exclude Substance Abuse treatment information
INITIAL

_____ Exclude Behavioral Health treatment information
INITIAL

_____ Exclude other (Specify): _____
INITIAL

RE-DISCLOSURE: If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected.

This authorization is effective immediately and will remain in effect for one (1) year or until _____ (date or event). I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the address where I received care. My revocation will be effective upon receipt, but will not be effective to the extent that CCHS has acted in reliance upon this Authorization. I have a right to receive a copy of this Authorization. If I am being asked by CCHS to authorize this disclosure, I have a right to inspect or obtain a copy of such health information disclosed. I may refuse to sign this Authorization. Neither treatment, payment, enrollment or eligibility of benefits will be conditioned on my providing or refusing to provide this Authorization.

SIGNATURES

DATE	PATIENT SIGNATURE	
AUTHORIZED SIGNATURE (IF OTHER THAN PATIENT)		RELATIONSHIP
SIGNATURE OF HOSPITAL STAFF WHEN REQUIRED		
EMPLOYEE NAME		DATE