OLE HEALTH

Patient Label

RELEASE OF INFORMATION

Patient Name: _____ DOB: _____ Phone: (____)_____

Address: _____ City: _____ State: _____ Zip: _____

OLE Health Centers (OLE) make reasonable efforts to limit disclosure of Protected Health Information to the minimum amount of information necessary to accomplish the intended purpose.

I authorize OLE to (select one): ____ Release my records to: ____ Request my records from:

Person/Organization: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: (____)_____ Fax Number: (____)_____

Reason For Request (select all that apply): ☐ Continuity of Care (Date of Appointment):_____

☐ Insurance ☐ Other:_____

Date range of records authorized by this Request: From _____ /_____/_____ To _____ /_____/_____

Mode of Release: ☐ Paper Copy ☐ CD/USB (Dental Imaging Only)

Delivery Method: ☐ Pickup (if applicable) ☐ Fax ☐ Mail

Type of Records Requested:

_____ Dental Records ☐ Dental Records (Dental History and Visit Information) ☐ Dental Imaging (X-ray)

_____ Medical Records

☐ All Personal Health Information (Visit Summaries, Prenatal Care Notes, Labs, Imaging, Medication List, etc.)

Specified Records Only:

☐ Lab Results ☐ Imaging Results ☐ Medications ☐ Problem List ☐ Immunizations ☐ Physical Screens

☐ Consultation Notes (specify):_____

☐ Prenatal/Postpartum Records:_____

☐ Other (please describe): _____

Sensitive Patient Information

The following information will not be released unless you specifically authorize us to do so by checking the box(es) below:

☐ Sexual/Reproductive Health/Gender Affirming Care—Birth control, abortion, STI treatment, gender-related care (CMIA §56.11)

☐ Information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§5328, et seq.)

☐ Release of HIV/AIDS test results (Health and Safety Code §120980(g)).

☐ Release of genetic testing information (Health and Safety Code §124980(j))

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NOTE:

Your health record may include information that references HIV/AIDS, alcohol/drug or behavioral/mental health services. The actual treatment records from HIV/AIDS, alcohol/drug, and/or behavioral/mental health will not be disclosed unless specifically requested on page one.

EXPIRATION:

RELEASE OF INFORMATION REQUEST:
This authorization shall become effective immediately and shall **remain in effect for one (1) year** from the date signed unless a different date is specified here: _____ / _____ / _____.

ACKNOWLEDGEMENTS:

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to any OLE Health Center site.
- My revocation will be effective upon receipt but will have no impact on uses or disclosure made while my authorization was valid.
- I have a right to receive a copy of this authorization
- I may inspect and obtain a copy of the health information of which I am authorizing the use or disclosure of my health information.
- I may be charged a fee for large records requests (maximum fee of $10 per qualifying request)

RESTRICTIONS

California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

SIGNATURES:

Name (Printed): _____ Signature:_____ Date:_____

If signed by other than the patient, print name and relationship:

Name (Printed): _____ Relationship to Patient: _____

Signature:_____ Date:_____

REVOKE: I understand and acknowledge that revocations/cancellations of this designation shall not apply to information that has already been released or affect actions taken by OLE Health prior to this request.

Please sign and date to revoke this authorization: Signature: _____ Date: _____