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SANTA CLARA VALLEY MEDICAL CENTER

SCVMC Authorization for Use and/or Disclosure of Protected Health Information AMBULATORY and COMMUNITY HEALTH SERVICES

Please check the clinic location that applies:

☐ **SCVHHS Employee Health-Medical Records Div.**
2400 Moorpark Ave., Suite #100 • San Jose, CA 95128
Phone:(408)885-4730 • Fax:(408)885-4728

☐ **Valley Health Center East Valley-Medical Records Div.**
1993 McKee Road • San Jose, CA 95116
Phone:(408)254-6346 • Fax:(408)254-6484

☐ **Valley Health Center Fair Oaks-Medical Records Div.**
660 S. Fair Oaks Avenue • Sunnyvale, CA 94086
Phone:(408)992-4974 • Fax:(408)992-4979

☐ **Valley Health Center Lenzen-Medical Records Div.**
976 Lenzen Avenue-Basement • San Jose, CA 95126
Phone:(408)792-5586 • Fax:(408)947-8778

☐ **Valley Health Center San Martin-Medical Records Div.**
90 Highland Avenue • San Martin, CA 95046
Phone:(408)686-2205 • Fax:(408)686-2288

☐ **Valley Health Center Silver Creek-Medical Records Div.**
1620 Capitol Expressway • San Jose, CA 95121
Phone:(408)494-7511 • Fax:(408)238-4293

☐ **Valley Health Center Tully-Medical Records Div.**
500 Tully Road • San Jose, CA 95111
Phone:(408)817-1454 • Fax:(408)817-1449

AUTHORIZATION: I give permission to

_____
(Name of Person/Organization Allowed to Release Records)

to use and release to _____,
(Name of Person/Organization Allowed to Receive the Records)

_____
Address City State Zip

for the records and information, as identified below, related to:

_____
Last Name First Middle Initial

_____
Medical Record Number Date of Birth Telephone Number

RECORDS: *(Important: check the appropriate box or boxes and initial or sign and date as required.)*

1. ☒ **MEDICAL RECORDS* - Initials:** _____

*References to the following types of information may be in or part of your Medical Records and if you want any of these types of information to be released with your Medical Records you must sign and date next to each type:

☐ **Drug/Alcohol Treatment Information** - Sign and Date: _____

☐ **Genetic Testing Information** - Sign and Date: _____

☐ **Reference to or Results of a HIV Blood Test Information** -
Sign and Date: _____

2. ☐ **MENTAL HEALTH RECORDS** - Sign and Date: _____

3. ☐ **OTHER (*Please be specific*)** _____

_____

DISTRIBUTION: WHITE-Chart CANARY-Patient

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LIMITATION ON RELEASE: The following is a specific description ("limitation") of the record(s) checked above and date(s) of service. (If no limitation, please write "No Limitation")

_____

_____

USES: The person who receives the health information can use it only for the following reason(s):

_____

_____

I understand that the person who receives the information cannot use the information for anything else or disclose the information to anyone else unless I give them a written authorization or the law allows it.

DURATION: This authorization is valid immediately and will be valid until _____ *(give date)*. If I do not write in a date, it will expire six months from the date it was signed.

ADDITIONAL COPY: I understand that I have a right to receive a copy of this authorization if I ask for it. Copy requested and received: ☐ Yes ☐ No _____ *(Initial)*

CANCELLATION: I understand that I have a right to cancel this authorization any time. A cancellation (1) must be in writing, (2) sent or given to the health information management department at the address on the top of this form, and (3) is effective when it is received by the department. A cancellation will not apply to actions already taken by SCVMC under this authorization or if the authorization was required for getting insurance coverage and the insurer has a legal right to contest a claim.

CONDITIONS: I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on my giving or refusing to give this authorization except if my treatment is related to research, or if health care services are given to me only for creating protected health information for release to a third party. I also understand that I may refuse to sign this authorization.

SIGNATURE: _____

Patient/Representative Date

If signed by other than patient, state relationship and authority to sign: _____

Signature of witness: _____ Date: _____

FOR MENTAL HEALTH USE ONLY

Complete the following if the patient is the person authorizing release of his/her records subject to California Welfare and Institutions Code Section 5328: The undersigned (the physician, licensed psychologist, or social worker with a masters degree in social work), who is in charge of the patient, hereby (approves)(disapproves) the release of information and records to Requestor. If disclosure is disapproved, give reasons below. Also note below or attach any restrictions on the release of records. (No approval is required for release to patient's attorney.)

_____

_____

_____ _____ _____

Dated Physician/Psychologist/Social Worker Degree

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