1828 E. Cesar E. Chavez Avenue
Suites 4100, 4300, 5000 & 6100
Los Angeles, CA 90033
Tel 323-987-1200 Fax 323-987-1211

White Memorial Community Health Center

1701 E. Cesar E. Chavez Avenue
Suites 456
Los Angeles, CA 90033
Tel 323-987-1200 Fax 323-987-1211

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I. PATIENT INFORMATION

Name _____ Date of Birth _____

Address _____

City/State/Zip _____ Phone _____

II. RELEASE OF INFORMATION Please complete all fields in order for request to be processed.

☐ I authorize White Memorial Community Health Center to release information to:

☐ I authorize White Memorial Community Health Center to obtain information from:

Facility receiving health information	
Name of person	
Address	
City, State Zip	
Phone	Fax
Email	

Information to be released:

☐ All health records

☐ Health records for the following dates: _____

☐ Health records for the following condition: _____

☐ Other (X-ray, billing, etc): _____

You may release information regarding testing diagnosis, and treatment for (check all that apply): ☐ HIV/AIDS virus ☐ Sexually transmitted diseases ☐ Drug and /or alcohol use ☐ Psychiatric disorders/Mental Health

Reason for the release: ☐ Personal ☐ Doctor ☐ Attorney ☐ Insurance ☐ Other _____

III. PATIENT'S RIGHTS

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. If I do, it will not affect any actions already taken by White Memorial Community Health Center (WMCHC) based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, I must write a letter to WMCHC. This information may be subject to redisclosure and may no longer be protected by federal or state privacy laws.

This authorization expires _____ (if left unsigned, the 1 year from date of this authorization or as required in RCW70.02.030(6), whichever is shorter.)

Patient or legally authorized individual signature _____ **Date** _____

Printed Name _____ **Relationship** _____

OFFICE/PROVIDER APPROVAL: _____