ALAMEDA COUNTY HEALTH CARE FOR THE HOMELESS
1404 Franklin Street, Suite 200, Oakland, CA 94612
TEL (510) 891-8950
www.achch.org

AUTHORIZATION TO RELEASE OR OBTAIN PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial**

Date of Birth | **Social Security No.** | **Home Phone** | **Work Phone** | **Extension**

Street Address | **City** | **State** | **Zip Code**

I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION BE RELEASED FROM:

Alameda County Health Care for the Homeless (510) 891-8950
Name | **Phone Number** | **Extension**

1404 Franklin St., Suite 200, Oakland, CA 94612
Street Address | **City** | **State** | **Zip Code**

I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION BE RELEASED TO:

Name (Individual/Organization) | **Phone Number** | **Extension**

Street Address | **City** | **State** | **Zip Code**

INFORMATION REQUESTED

(☐) All medical records, including Mental Health and HIV treatment
(☒) Other: **1) ACHCH Medically Frail program eligibility status, and 2) If eligible and matched to Medically Frail unit, location of unit and required documents needed to complete ACHCH Medically Frail application.**

To limit information to a specific date range, check here (☐) and fill-in the dates below:

For Dates of Service from _____ **through** _____

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I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization and that I am entitled to receive a copy of this authorization after I sign it.

EXPIRATION: This Authorization expires twelve (12) months from: (☒) **the date signed.**
To specify a different expiration, check here (☐) and fill-in the expiration date:_____

PURPOSE OF REQUESTED USE OR DISCLOSURE OF RECORDS/PROTECTED HEALTH INFORMATION:

(☒)Purpose: **1) Medically Frail Application Assistance/Eligibility Status, and 2) Medically Frail Unit Placement/Care Coordination**

_____ _____ _____
Signature of Patient **Print/Type Name** **Date**

If required:

_____ _____ (☐)**Parent** _____
Signature of Parent or Guardian **Print/Type Name** (☐)**Guardian** **Date**

REVOCATION: I understand that I have a right to revoke this authorization at any time unless action has been taken in response to or in reliance on this authorization. I understand that my revocation must be in writing and presented to an Alameda County Health Care for the Homeless (HCH) representative in order to revoke the authorization granted to HCH. I further understand that I must present a separate written revocation to any other person or entity that I have authorized to receive or use my individually identifiably health information above in order to revoke the authorization granted to that person or entity.

WARNING: PROHIBITIONS ON USAGE, TRANSFER OR REDISCLOSURE OF INFORMATION, except as required by State or Federal laws, use of information released for other than the stated purpose, or redisclosure or transfer of this information to any person or entity not named herein is PROHIBITED. An additional written authorization must be obtained for any proposed new use of the information or for its redisclosure or transfer of such information. The information disclosed may be subject to redisclosure and may no longer be protected by federal privacy regulations.

MEDICAL RECORDS WILL BE RETAINED FOR SEVEN (7) YEARS FOLLOWING A PATIENT'S DISCHARGE FROM OUR AGENCY, WHEREUPON THEY WILL EITHER BE DESTROYED OR, IF REQUESTED, RETURNED.