

**Authorization for Release of Confidential Information***(Please fill out both sides of this form)*

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Consumer's Last Name	First Name	Middle Name	Date of Birth
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Street Address	City	Zip Code	Daytime Telephone
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Social Security Number **\*(Required)****I, request that my protected health information (PHI) from:**

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Health Care Provider Name	Telephone
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Street Address	City/State	Zip Code	FAX # (if known)
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**Be disclosed to:** ACBH – QA Office  
Consumer Assistance  
2000 Embarcadero Cove, Suite 400  
Oakland, CA 94606

**I authorize the following PHI to be released from my medical record(s):**

- |   |  |
|---|--|
| <input type="checkbox"/> Emergency Room Record              | <input type="checkbox"/> Pathology Slides/Report             |
| <input type="checkbox"/> Laboratory Reports                 | <input type="checkbox"/> Itemized Billing Records            |
| <input type="checkbox"/> Radiology Reports                  | <input type="checkbox"/> Discharge Summary                   |
| <input type="checkbox"/> Immunization Record                | <input type="checkbox"/> History and Physical, Consultations |
| <input type="checkbox"/> Complete Medical Record (all pgs.) | <input type="checkbox"/> Operative Reports                   |
| <input type="checkbox"/> Other: _____                       |  |



**State and Federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained** (include dates where appropriate):

- Mental Health Records  Yes  No
- Psychotherapy Records  Yes  No
- HIV Testing and Results  Yes  No
- Alcohol, Drug, or Substance Abuse Record  Yes  No
- Genetic Records  Yes  No

**Covering the period of healthcare from:** Specific Date(s) \_\_\_\_\_ to \_\_\_\_\_ **OR**  
 All past, present, and future encounters/visits

**Purpose for requesting information:** Resolving my grievance or appeal request

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate six (6) months from the date of consent. The signer may revoke this release in writing or by verbally informing Consumer Assistance.

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Client or Authorized Representative Signature Date

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Print Name Relationship to Patient (if applicable)

**Any disclosure of medical records information by the recipient(s) is prohibited except when implicit in the purpose of the disclosure. PROHIBITION ON RE-DISCLOSURE OF PROTECTED SUD INFORMATION: 42 CFR Part 2 prohibits unauthorized disclosure of these records.**