Western Sierra Medical Clinic
Better Health Together

# Release of Health Information

844 Old Tunnel Rd.
Grass Valley CA, 95945
wsmcmed.org

| | | | |
|---|---|---|---|
| **1** | Patient's Last Name | Patient's First Name | Date of Birth |
| **2** | ☐ Please release information/send records FROM WSMC* (To Person/Facility Below) ☐ Please release records TO WSMC (From Person/Facility Below)<br>***Transferring your primary care outside of WSMC may delay your appointment for specialty care.** | | |
| **3** | Full Name of Organization/Provider/Individual (or Self) | | |
| | Address | | City |
| | State / Zip | Phone # with area code | Fax with area code |
| | **Transmit:**<br>Verbally □ Electronic: □ Fax □ U.S. Mail: □ CD □Paper | | |
| **4** | **CHOOSE ONLY ONE (1) Per Release**<br>____Medical ____HIV/AIDS Testing & Treatment ____Alcohol/Substance/Drug Use Treatment<br>____Dental ____Behavioral Health ____ Psychotherapy Notes ____Other: | | |
| **5** | **Time Frame:** ☐Last Visit ☐Past Year ☐All ☐Other: | | |
| **6** | ☐All records ☐Just these: | | |
| **7** | **Reason for release:** ☐Personal ☐Transfer of Care ☐Other: | | |
| **Authorization** | By signing, I authorize use/disclosure of my health information and understand that:<br>• I may revoke this authorization at any time by contacting WSMC in writing.<br>• This authorization is valid for 1 year maximum or this earlier date: ____ / ____ / ____.<br>• The recipient of your health information may not further disclose your information without obtaining another authorization from you.<br>• All Alcohol & Substance Abuse health information is protected and only releasable with a separate express written consent of the person it pertains to.<br>• My treatment/eligibility of care is not based on this authorization.<br>• This authorization is voluntary and a photocopy or fax of this authorization is as valid as the original<br>• I have the right to a copy of this authorization. | | |

**SECTIONS 1-7 MUST BE COMPLETED TO BE VALID**

**Signature**

_____**Date:** ____ / ____ / ____ **Tel:** (_____)_____ - _____

**If not patient:** ☐Patient's Representative

Print Name and State Relationship: _____

**RECEIVED BY:**

**PLEASE WRITE CLEARLY OR WE WILL NOT BE ABLE TO PROCESS THIS REQUEST.**

Western Sierra Medical Clinic does not discriminate on the basis of race, color, national origin, sex, age or disability, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sexual orientation, or gender identity or expressions.