Consent for Use or Sharing of Health Information

Completing this document allows the sharing of health information about you.
For the consent to be effective, you must fill out all the sections.

Patient Name______________________________ Date of Birth________________

Health Record Number (for hospital use only):____________________

USE AND SHARING OF HEALTH INFORMATION – Send information to the following location

1. **I hereby allow** ____________________ (Sending person or organization) **to give my information to** ____________________ (Receiving person or organization)

   Address____________________________ City ____________________

   State____ ZIP__________ Phone__________________ **Fax** __________________

   I hereby allow ____________________ (Sending person or organization) **to give my information to** ____________________ (Receiving person or organization)

   Address____________________________ City ____________________

   State____ ZIP__________ Phone__________________ **Fax** __________________

2. **The following information** (Check all that apply):

   a. ☐ All health information about my medical history. Including mental or physical condition and treatment received. (Please include dates of service you are requesting): ____________________

   ☐ Only the following records or types of health information. (Please include dates of service you are requesting):____________________

   b. I allow release of the following information. **(Check and initial all that apply)**:

   ☐ Mental health treatment information......_____ (initial) Date of service ____________

   ☐ HIV test results......_____ (initial) Date of service ____________

   ☐ Sexually Transmitted Infection......_____ (initial) Date of service ____________

   ☐ Reproductive Care......_____ (initial) Date of service ____________

   ☐ Gender Affirming Care......_____ (initial) Date of service ____________

   ☐ The following substance use disorder treatment information:____________________

   ____________________ _____ (initial)

PURPOSE

Purpose of request: ☐ Patient request OR ☐ Other:______________________________

Limitations, if any:______________________________

CONSENT EXPIRATION

This consent expires in 6 months or on this date: ____________________

MY RIGHTS

- If I refuse to agree to release certain types of records, I understand this will not affect my care.
- I may view or get a copy of what I agree to be shared.
- I may revoke this consent at any time, but I must do so in writing and submit it to the following address:

  Enloe Health
  1531 Esplanade
  Chico, CA 95926
  Attn: Health Information Management

- If I decide to revoke my request, records will not be sent after the date when Enloe Health receives notice of my decision.
- If I have signed a consent at an earlier time, my records may have already been sent.

x______________________________ ____________________
Signature of Patient or Authorized Person **Date**

____
If signed by Authorized Person, relationship to patient

x______________________________
Witness Signature