Authorization to Release Information

○ 140 Litton Drive Suite 100, Grass Valley CA 95945
○ 11400 Pleasant Valley Road Penn Valley, CA 95946
scphysicians.com

1	Patient's Last	Patient's First		Date of Birth
2	☐ Please release information/send records **FROM** SCP* (To Person/Facility Below)		☐ Please release records **TO** SCP (From Person/Facility Below)	
3	Full Name of Organization/Provider/Individual (or Self)			
	Address			City
	State	Zip	Phone # with area code	Fax with area code
	Transmit: Verbally ☐ Electronic: ☐ Fax ☐ U.S. Mail: ☐ CD ☐USB ☐Paper			
4	**CHOOSE ONLY ONE (1) Per Release** ____Medical_____HIV/AIDS Testing & Treatment_____Alcohol/Substance/Drug Use Treatment ____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:

- I may revoke this authorization at any time by contacting SCP in writing.
- This authorization is valid for 1 year maximum or this earlier date:_____/_____/_____.
- The recipient of your health information may not further disclose your information without obtaining another authorization from you.
- All Alcohol & Substance Abuse health information is protected and only releasable with a separate express written consent of the person it pertains to.
- My treatment/eligibility of care is not based on this authorization.
- This authorization is voluntary and a photocopy or fax of this authorization is as valid as the original
- 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 (State Relationship____________________)

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

Sierra Care Physicians 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.

Pediatrics- Phone 530-272-9780 Fax 530-272-0156 **Family**- Phone 530-272-9770 Fax 530-272-9796
Penn Valley- Phone 530-432-7023 Fax 530-432-7026