Authorization for Release of COVID-19 Related Records

The following form authorizes the medical provider designated below to disclose or discuss specified medical records or information to a designated recipient.

Patient Information

Patient Name: _____

Date of Birth: _____

Requesting Facility Name Plumas District Hospital

Phone: 530-283-2121 **Fax:** 530-283-7197

Authorized Recipient Name Feather River College

Recipient Address: 570 Golden Eagle Ave, Quincy CA 95971

Recipient Telephone: 530-283-0202

Recipient Fax: 530-283-3757

Health Information Requested (*check all that apply*)

COVID-19 related records:

- ☒ Lab Results
- ☐ Visit Records
- ☐ Imaging Results

This authorization is effective for one year from the date of the signature unless a different date is specified here: _____

This authorization may be revoked upon written request, but any revocation will not apply to information disclosed before receipt of the written request. A copy of this authorization is as valid as the original. The undersigned has the right to receive a copy of this authorization. *Notice*: Once the requested health information is disclosed, any disclosure of the information by the recipient may no longer be protected under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient (Student) signature*: _____ Date: _____

Print name: _____

If not signed by the patient/student, please indicate relationship to the patient:

_____

(Parent, Guardian, Conservator or Legal Representative)

For Internal Use Only

Date of Request: _____ Contact Person:_____