MCHC HEALTH CENTERS

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

For this form to be valid, all sections must be filled out completely.

CONTACT HEALTH INFORMATION: Phone: (707) 472-4636 Fax: 707-467-0857

1. Patient Information

Name of Patient ______________________ Date of Birth ______________________

Other or previous names used ______________________ Phone Number ______________________

Text Message? Yes ☐ No ☐

Address ______________________ City __________ State __________ Zip __________

2. Authorization to Use or Disclose Patient's Health information

☐ I hereby authorize Mendocino Community Health Clinics, Inc. (MCHC) to Release to

____

Name of the person or facility authorized to receive your health information

Address ______________________ City __________ State __________ Zip __________

Phone Number ______________________ Fax ______________________

Format:
☐ CD ☐ Print

Delivery Type:
☐ Fax ☐ Mail ☐ Pick-up

3. Authorization to Use or Disclose Patient's Health information

☐ I hereby authorize the following to Release records to Mendocino Community Health Clinics, Inc. (MCHC):

____

Name of the person or facility authorized to release your health information

Address ______________________ City __________ State __________ Zip __________

Phone Number ______________________ Fax ______________________

MCHC Health Centers is dedicated to providing the highest quality healthcare to everyone in our communities. MCHC is an equal opportunity provider and employer.

4. Purpose of this release of patient's health information

☐ At the request of patient or patient's representative ☐ Other______________________________

Limitations (if any): ____

____

5. Please specify the types of health information to be released

Type(s) of health information to be disclosed:____

____

☐ A. All health information pertaining to my medical history, mental or physical condition and treatment received.

☐ B. Only the following records or types of health information (including any date(s) of treatment):

____

____

The following information will <u>NOT</u> be released unless you specifically authorize its release by marking the relevant areas below:

☐ Information pertaining to drug and alcohol abuse, diagnosis, or treatment

☐ Information pertaining to mental health diagnosis or treatment (other than psychotherapy notes)

☐ Release of HIV/AIDS test results, diagnosis, or treatment

☐ Release of genetic testing information

[A separate authorization is required to authorize the disclosure or use of psychotherapy notes] as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by federal law and regulations

6. EXPIRATION: This authorization expires on (date):____

(If no date specified, expiration will be one year from the date signed by patient (or patient representative).

7. NOTICE and STATEMENT OF RIGHTS

Notice: MCHC and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of I unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

If you are a parent or legal guardian making a request regarding records of a minor, you will not have access to entries for health care to which, by law, the minor may consent without parental involvement. If you are a minor, you will only have access to those portions of your record describing health care for which you may consent, under applicable law, without involvement of parents. A fee of up to 25 cents per page plus postage may be charged for copies of medical records per California Statute Health and Safety Code sections 123100-123149.

Your Rights: This Authorization to release health information is voluntary. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on your signing this Authorization.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to: Mendocino Community Health Centers, 333 Laws Ave, Ukiah, Ca 95482. The revocation will take effect when MCHC receives it, except to the extent that MCHC or others have already relied on it. Unless otherwise revoked, this Authorization expires 12 months after the date of my signing the form. **You are entitled to receive a copy of this Authorization.**

____
Print Name (Patient, Parent, Legal Guardian)

____
Signature (Patient, Parent, Legal Guardian)

____
Date

____
Time

____
Relationship to Patient

MCHC HEALTH CENTERS

FOR OFFICIAL USE ONLY

Release received by (name of MCHC staff) ______________________________

Department ______________________________

☐ Faxed or Mailed Release Date__________ Staff Initials__________

☐ Faxed or Mailed Records Date__________ Staff Initials__________

☐ Completed, all patient records have been sent or received and no further action is required.