MCHC HEALTH CENTERS

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

NOTE: THIS FORM IS USED TO AUTHORIZE RELEASE OF MEDICAL RECORDS

For this form to be valid, sections 1-6 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 ______________________ Medical Record # ______________________

Address ______________________ Phone Number ______________________

Message? ☐ Yes ☐ No

2. Person or Facility that currently *has* patient's health information

I hereby authorize ____

Name of the person or facility that has your health information

Address ______________________ City ____________ State ________ Zip ____________

Phone Number ______________________ Fax ______________________

3. Person or Facility that will receive patient's health information

I hereby authorize ____

Name of the person or facility that will receive your health information

Address ______________________ City ____________ State ________ Zip ____________

Phone Number ______________________ Fax ______________________

Format: ☐ CD ☐ Print

Delivery Type: ☐ Fax ☐ Mail ☐ Pick-up

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

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

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

Type(s) of health information:____

Date(s) of treatment:____

The following information will NOT 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
- ☐ Release of HIV/AIDS test results, diagnosis or treatment
- ☐ Release of genetic testing information

6. 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. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. 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 signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

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 Clinic, 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

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.