Medical Record #____________

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide *all* information requested may invalidate this authorization.

Patient Name: (Print) ____________________ Birth Date: ____________________________
Address: ______________________________ Social Security #: _______________________
City: ________________ State: _________ Zip: _______ Phone: _______________________

I AUTHORIZE: ____
(Facility or other provider)

TO DISCLOSE TO: ____
(Persons/organizations authorized to *receive* the information)

At the following address: ____
(Street, City, State, and Zip)

(3) Dates of treatment: From (Date): ______________ to (Date): ________________________

(4) Information disclosed for the purpose of: ☐ Medical Care ☐ Insurance/Legal Claim
☐ Patient/Personal ☐ Other Please Explain: _______________________________

(5) Type of information to be released: (Check all applicable categories)

- ❑ Medical history, examination report
- ❑ Operation reports
- ❑ Laboratory report
- ❑ Pathology reports
- ❑ Emergency room records
- ❑ **Complete** medical record
- ❑ Discharge summary
- ❑ Consultation reports
- ❑ X-ray reports

I SPECIFICALLY AUTHORIZE RELEASE OF THE FOLLOWING INFORMATION (CHECK AS APPROPRIATE)

- ❑ Psychiatric/Mental Health information to be released
- ❑ HIV status information to be released
- ❑ Drug and/or Alcohol Abuse information or an employment related drug panel.

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.

PLEASE SEE BACK FOR MORE INFORMATION AND AUTHORIZED SIGNATURE

EXPIRATION

This authorization expires on (date): ____

MY RIGHTS

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

  Mountain Communities Healthcare District
  P O Box 1229
  Weaverville CA 96093
  ATTN: Health Information Department

  My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have the right to receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure 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 it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNATURE

Date:__________________________________Time:___________________________AM/PM

SIGNED: ____

(Patient) or (Legal Representative)

If signed by a person other than the patient, indicate relationship:

____

(Relationship to Patient)

COPYING AND BILLING MAY BE DONE BY:

PROFESSIONAL MEDICAL COPY
1768 WEST STREET, REDDING CA 96001
(530) 241-2971 (800) 223-6891
Fax: (530) 241-6928

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