Mountain Communities Healthcare District

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: ____ Phone:__________________________
City: __________________________ State: __________________ Zip: ______________________

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 or fax number)

(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 ☐ Discharge summary
☐ Operation reports ☐ Consultation reports
☐ Laboratory report ☐ X-ray reports
☐ Pathology reports ☐ Emergency room records
☐ **Complete** medical record

I understand that the information in my health record may include information relating to any of the following:
Sexually transmitted disease,
Acquired Immunodeficiency Syndrome (AIDS),
Human Immunodeficiency Virus (HIV),
Behavioral or mental health services,
Alcohol and/or drug abuse or an employment related drug panel.

_____________________________________ ____________________________________
[**Signature** of Patient or Legal Representative] [**Printed name** of person signing form]

This authorization expires on (date): ____

over→

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)

FOR QUESTIONS CALL:

Trinity Hospital Phone: 530-623-5541 ext 3219 Fax: 530-623-3073
Trinity Health Clinic Phone: 530-623-4186 Fax: 530-623-4397
Hayfork Health Clinic Phone: 530-628-5517 Fax: 530-628-5524

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

THERE WILL BE A CLERICAL FEE AND A FEE PER PAGE, DETERMINED ON THE VOLUME OF THE MEDICAL RECORD, PLUS SHIPPING AND HANDLING AT COST FOR MEDICAL RECORD COPIES