MORONGO BASIN
COMMUNITY HEALTH CENTER
A SERVICE OF MORONGO BASIN HEALTHCARE DISTRICT
Phone: 760-365-9305

## AUTHORIZATION FOR RELEASE OF (PHI) PROTECTED HEALTH INFORMATION

Name of Patient: _____ Date of birth: _____

Other names used: _____ Telephone number: _____

I, the undersigned, authorize the release of PHI specified below from the medical records of the above named patient.

**THE PURPOSE OF THIS RELEASE IS (CHECK ONE OR MORE):**
❒ Insurance ❒ Continuing medical care ❒ School ❒ Personal use (*fee applies*) ❒ Legal purposes
❒ Social Security/Disability ❒ Other (state reason) _____

**INFORMATION TO BE RELEASED/ACCESSED**: Date of service from _____ to _____
❒ Treatment Records ❒ Medical Consultations ❒ Radiology Reports ❒ Laboratory Reports

❒ Immunization Record ❒ Dental Record ❒ HIV _____*initial* ❒ Drug/Alcohol Record _____*initial*

❒ Mental Health Records *(other than psychotherapy)* _____ *initial* ❒ Other: _____

**RELEASE INFORMATION TO**:
The above information may be released as specified below: name or title of the individual/organization to which Patient Health Information is to be released and the appropriate fax number or mailing address.

Forward to: _____ Phone: _____

❒ By Fax: _____ ❒ By mail *(address):* _____

From: _____ Phone: _____ Fax: _____

Address: _____

**DURATION AND AUTHORIZATION**:
Unless otherwise revoked, this authorization will expire on the following date, _____. This authorization shall remain in effect until the above-described disclosure is complete but shall not extend beyond 6 months from the date of signature. Signing this form is voluntary. I understand I have the right to revoke this authorization and the right to inspect or get a copy of the material to be disclosed. **See reverse side of this form for details on disclosure of information and my rights.** I have read both pages of this form and voluntarily authorize and request the disclosure above. I authorize the use of a copy including facsimile, of this form for disclosure as described above.

**AURTHORIZING SIGNATURE**: *(name)* _____ Date: _____

Relationship to the Patient: ❒Patient ❒ Legal Guardian Other: _____

*Additional information is provided on the reverse side of this form*

**NOTICE**

Morongo Basin Community Health Center and many other organizations such as hospitals and health plans are required by law to keep your PHI confidential. If you have authorized the disclosure of your PHI to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

The information in your health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about treatment for alcohol and drug abuse, and/or behavioral or mental health services.

**MY RIGHTS**

**Voluntary:** I understand authorizing this disclosure of the information identified on the reverse side is voluntary. I need not sign this form to ensure healthcare treatment.

**Right to revoke:** I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and submit to Morongo Basin Community Health Center 58383 29 Palms Hwy. Suite 101 Yucca Valley, CA 92284. The revocation will take effect upon receipt. I understand that the revocation will not apply to information that has already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

**Right to inspect:** I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 CFR 164.524 and that I have the right a copy of this authorization.

**Question:** If I have questions about disclosure of my health information, I can contact Morongo Basin Community Health Center at 760-365-9305.

**Fees:** For Personal use, no charge for the first 15 pages and $0.25 per additional page. Fees will be collected prior to release. Request is process within 15 days of receipt of the request. We will contact you by phone when the requested information is available.

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**---------- FOR OFFICE USE**

Name of staff person who verified identification/representative_____

Name of Provider: _____

I hereby approve / disapprove the release of information and records to the patient or legal representative specified herein. NOTE: If disclosure is disapproved, give reasons and note any restrictions to the release of information.

_____

_____

Provider's Signature _____ Credential _____ Date _____