

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Page 1 of 2

**1. PATIENT INFORMATION**

Patient Name (Last, First): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone #: \_\_\_\_\_

**2. PARTY TO RECEIVE INFORMATION (SELECT ONE)**

☐ Patient      ☐ Individual or Organization Name \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Fax: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**3. PARTY TO RELEASE INFORMATION (SELECT ONE)**

Organization Name: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Fax: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**4. PURPOSE**

☐ Continuity of Care      ☐ Personal Use (\*fee applies)      ☐ Legal      ☐ Other (specify): \_\_\_\_\_

**5. INFORMATION TO BE RELEASED**

**A. Protected Health Information (select only 1, 2, or 3)**

☐ 1. All information related to my care

☐ 2. The following information:

☐ Mental health information

☐ Dental information

☐ Medical information

☐ Other information (specify): \_\_\_\_\_

☐ 3. Only HIV test results. I understand that HIV test results are released separately from other health care records. **I agree that by checking this HIV test results box, I authorize the release of specially protected health information. A new authorization will be required for subsequent disclosures.**

**B. Specially Protected Health Information (select if applicable)**

I understand the types of information below have extra confidentiality protections required by law. I would like the following specially protected health information released if it is in my record:

☐ Psychotherapy notes

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Page 2 of 2

☐ Substance use treatment records**C. Dates of Service (select one)**☐ All dates of service☐ Only dates of service from (insert dates): \_\_\_\_\_ - \_\_\_\_\_**6. METHOD OF RELEASE OF INFORMATION**☐ Fax☐ Patient Pick-Up☐ Mail☐ Other (Specify): \_\_\_\_\_**7. EXPIRATION DATE**

This authorization will remain in effect as follows (select one):

☐ This authorization shall remain in effect until revoked by the patient☐ This authorization expires one year from the date signed below☐ This authorization expires on the following date: \_\_\_\_\_.**8. RIGHTS**

I understand:

- I may refuse to sign this authorization; refusal will not affect my ability to obtain treatment.
- I may revoke this authorization at any time by providing written notification to Morongo Basin Community Health Center (MBCHC), Medical Records Department.
- If I revoke this authorization, my revocation will be effective upon receipt but will have no impact on uses or disclosures made while my authorization was valid.
- I may request a copy of this signed form.
- Information disclosed pursuant to this authorization may be subject to redisclosure by recipient and may no longer be subject to federal and state privacy law protection.
- Even if I do not authorize a release of health information, MBCHC may share my confidential information for treatment, payment, and health care operations and other purposes required or permitted by law.

**9. SIGNATURES**

Signature of Patient/Representative:

Date:

Print Name of Patient/Representative:

Relationship to Patient (If applicable):

*If you are the Representative, you must present documentation of your authority to act on behalf of the patient.*

*\*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 processed within 15 days of receipt of the request. We will contact you by phone when the requested information is available.*