MATHIESEN MEMORIAL HEALTH CLINIC

18144 Seco Street| PO Box 535
Jamestown Ca 95327
P. 209-984-4820| F. 209-984-4825
Mathiesen.Clinic@CRIHB.org

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

Name – Last, First MI			
Street Address	City	State	Zip
Medical Record/Member #	Date of Birth (MM/DD/YYYY) / /	Phone number	

RELEASED FROM:

Name of Provider/Organization/Individual/Other

Street Address

City State Zip

DISCLOSE TO:

Name of Provider/Organization/Idividual/Other

Street Address

City State Zip

INFORMATION TO BE DISCLOSED:

Date Range: ____/____/____ to ____/____/____
MM DD YYYY MM DD YYYY

Medical:

☐ Office Visits ☐ Immunization Records ☐ Medication List ☐ Psychiatric Progress Summary

☐ Procedures

☐ Specific information pertaining to: _____

Behavioral Health:

☐ Psychotherapy Notes (federal law requires court order) ☐ Psychiatric Evaluation ☐ Psychiatric Progress Summary

☐ Psychosocial Assessment ☐ Psychological Testing Summary ☐ Psychological Evaluation ☐ Behavioral Health Treatment Plan

☐ Alcohol/Drug Treatment Plan ☐ IEP

☐ Specific information pertaining to: _____

Federal and state laws require special permission to release certain information. Check applicable boxes to authorize release:

☐ Mental Health ☐ Alcohol/Drug Use ☐ Developmental Disabilities ☐ AIDS/HIV

MY RIGHTS REGARDING THIS AUTHORIZATION

Right to inspect or receive a copy of the health information to be used or disclosed: I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed.

Right to receive a copy of this authorization: I understand that if I agree to sign this authorization, which I am not required to do, I may request a signed copy of the form.

Right to refuse to sign this authorization: I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for healthcare benefits on my decision to sign this authorization.

MATHIESEN MEMORIAL HEALTH CLINIC

18144 Seco Street| PO Box 535
Jamestown Ca 95327
P. 209-984-4820| F. 209-984-4825
Mathiesen.Clinic@CRIHB.org

Right to revoke this authorization: I understand that written notification is necessary to revoke this authorization. To obtain information on how to revoke my authorization or to receive a copy of my withdrawal, I may contact Mathiesen Memorial Health Clinic. I am aware that my revocation will not be effective to uses and/or disclosures of my health information that the person(s) or organization(s) listed above have already made in reference to this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient

Further Disclosure: I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws. I understand that this information may be released electronically.

EXPIRATION DATE: This authorization is effective for one (1) year from the date signed unless otherwise indicated. ____/____/____
MM DD YYYY

Signature of Patient or Legal Representative_____ **Date:**____/____/____
MM DD YYYY

Relationship:_____

Patient is: ☐ Minor ☐ Incompetent/Incapacitated ☐ Deceased

Legal Authority: ☐ Legal Guardian ☐ Spouse of Deceased
☐ Health Care Agent ☐ Personal Representative
☐ Other: _____

MATHIESEN MEMORIAL HEALTH CLINIC

18144 Seco Street| PO Box 535
Jamestown Ca 95327
P. 209-984-4820| F. 209-984-4825
Mathiesen.Clinic@CRIHB.org

Instructions and Important Disclosure Information: Below you will find instructions for completion of this form, important information about your privacy rights, how we ensure your information is collected, used and disclosed in accordance with applicable laws and policies and our pledge to ensure and protect your privacy in this process. Patients may submit complaints about this process at any time by contacting the clinic privacy officer or the clinical manager.

1. Print patient's name, address, phone number, date of birth and medical record number.
2. Confirm authorization relates to Mathiesen Memorial Health Clinic records. Mathiesen Memorail Health Clinic may be prohibited from disclosure of records pertaining to other health care providers.
3. Print the name and address of the organization or individual to whom you wish to release records.
4. Check the box indicating the purpose of this disclosure.
5. (a) Insert the date range for which you are requesting release of records; (b) Specific description of records you are disclosing (e.g. only immunization records and lab reports). Note that additional authorization is required for mental health, alcohol/drug use/ developmental disabilities and AIDS/HIV (you must check the appropriate box if you want this information disclosed)
6. (a) Carefully review your rights regarding this authorization (e.g. your right to revoke); (b) The form must be signed by the authorized individual with legal authority to submit the request. If an individual other than the patient signs the form, the relationship and additional details about the nature of this relationship must be provided (d) Unless you specifically provide an expiration date, Mathiesen Memorial Health Clinic will release information pertinent to this authorization for a period of one year from the signature date; (e) Provide the signature of authorized individual.
   (f) Electronic signatures will not be accepted.
7. Submit the completed form to Mathiesen Memorial Health Clinic using one of the following options: (a) Mail the form via USPS to Mathiesen Memorial Health Clinic directed to the address noted; (b) Fax the form to the fax number provided on this form; (c) E-Mail the completed form as a PDF attachment to Mathiesen.clinic@CRIHB.ORG (note use of e-mail is considered an unsecured transmission); (d) Drop form off in person at the clinic.
8. Mathiesen Memorial Health Clinic upholds the patient's right to authorize or deny release of protected health information (PHI) beyond uses for treatment, payment or health care operations.
9. This authorization has been reviewed by Mathiesen Memorial Health Clinic staff that carefully screen what PHI is and is not authorized for disclosure under applicable federal and state laws and regulations.