



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

Last Name:		First Name:		MI:
Billing/Street Address:		City:	State:	Zip:
Medical Record Number: office use only	Date of Birth (MM/DD/YYYY)		Phone Number:	

RELEASED FROM:

DISCLOSE TO:

 Name of Provider/Organization/Individual/Other

 Name of Provider/Organization/Individual/Other

 Street Address

 Street Address

 City State Zip

 City State Zip

 Fax Number:

 Fax Number:

For Patients - Please Mark if you want: To Pick up Mailed

INFORMATION TO BE DISCLOSED

MEDICAL:

- Office Visits Immunization Records Medication List Lab(s) Radiology Report(s)
 Procedures Pathology Reports Specific Information pertaining to: _____

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

Behavioral Health:

- Psychiatric Evaluation Psychiatric Progress Summary Psychosocial Assessment Psychological Testing Summary
 Psychological Evaluation Behavioral Health Treatment Plan Alcohol/Drug Treatment Plan IEP

Psychotherapy Notes (Federal Law-requires court order) Specific information pertaining to: _____

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

 Behavioral Health Provider's Signature

_____/____/____
 Date

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

- Mental Health Alcohol/Drug Use Developmental Disabilities AIDS/HIV (chart notes and/or labs)

 Patient Signature

_____/____/____
 Date



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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.

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 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 person(s) or organization(s) 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 release electronically.

EXPIRATION DATE: This authorization is effective for one (1) year from the date signed below.

Signature of Patient or Legal Representative: _____ **Date:** ____/____/____

Relationship: _____ Legal Authority: Legal Guardian Spouse of Deceased
Patient is: Minor Incompetent/Incapacitated Deceased Health Care Agent Personal Representative
 Health Care Provider/PCP
 Other: _____

Office Use Only

Verification of ID: Yes No **Staff Initials:** _____ **Date:** ____/____/____

If no, Records sent to other Provider's office Records sent to _____

Date Received: ____/____/____

Date Completed: ____/____/____ **Staff Initials:** _____

Patient Information
Label