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:

Name of Provider/Organization/Individual/Other

Street Address

City State Zip

Fax Number:

DISCLOSE TO:

Name of Provider/Organization/Individual/Other

Street Address

City State Zip

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 ☐ Phycological 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, 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 released 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