



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/Healthcare Organization/Individual

 Name of Provider/Healthcare Organization/Individual

 Street Address

 Street Address

 City State Zip

 City State Zip

 Phone Number :

 Phone Number :

 Fax Number:

 Fax Number:

For Patients - Please select your record delivery method: To Pick up Mail Fax Encrypted Email

Email Address: _____

INFORMATION TO BE DISCLOSED

Please circle one or both: MEDICAL / DENTAL

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

Date Range: _____ to _____
 MM DD YYYY MM DD YYYY

Reason for Disclosure:

- Continuity of Care Public Health and Reporting
 Insurance and Billing Research and Studies
 Legal Proceedings Employment and Schooling
 Personal Access

Federal and State laws require special permission to release certain protected health information. Please check the applicable box, sign, and date to authorize release of the following records:

- AIDS/ HIV Chart Notes and Labs

 Signature:

 Date:

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.



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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.

NOTICE PROHIBITING RE-DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION

Notice to Recipients: This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see 42 CFR § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 CFR §§ 2.12(c)(5) and 2.65.

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

Relationship: _____

Patient is: Minor Incompetent/Incapacitated Deceased

*****When emailing or faxing the release back to us, please include a clear photocopy of your Driver's License, State ID, or passport.*****

- Legal Authority:
- Legal Guardian Spouse of Deceased
 - Health Care Agent Personal Representative
 - Health Care Provider/PCP
 - Other: _____

Please Note: You will receive your records within 30 days of the date that we receive your request. Paper records to be mailed may incur a fee of up to \$25. If you have any questions or if you need assistance completing this form, please call our Medical Records Department at (209)431-2936.

Office Use Only for Outgoing Records

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