Mendocino Coast Clinics, Inc.
205 South Street, Fort Bragg, CA 95437
707-964-1251
medicalrecords@mccinc.org

Patient Authorization to Disclose Protected Health Information

Patient Name _____ Date of Birth _____

Address _____

1. I authorize the following individual or Organization to disclose the above-named individual's health information as described below. Please note that MCC releases this information electronically via secure, encrypted messaging.

Release Information From:

☐ Mendocino Coast Clinics, 205 South St., Fort Bragg, CA 95437
☐ Other (*Specify facility/individual & address below, include phone/fax if known.)*

_____

_____

_____

_____

Release Information To:

☐ Mendocino Coast Clinics, 205 South St., Fort Bragg, CA 95437
☐ **Adult Fax:** 707-961-2722 ☐ **Pediatric Fax:** 707-964-6274
☐ **OB Fax:** 707-961-3471 ☐ **Email:** medicalrecords@mccinc.org
☐ Other (*Specify facility/individual & address below, include phone/fax if known.)*

_____

_____

_____

2. The type and amount of information to be used or disclosed is as follows (check off the appropriate items(s), and include other information, where indicated):

☐ Entire Record
☐ Immunization Record
☐ Most recent history and physical
☐ Laboratory results
☐ X-Ray and/or imaging
☐ Visit Notes
☐ Consultation reports from (please supply doctors' names) _____
☐ Dental Clinic Records
☐ Dental X-ray Films
☐ Mental Health Counseling/Drug &Alcohol Counseling
☐ Other (please describe)_____

3. My authorization pertains to information generated on the following date(s) or in the following time period:

_____

4. This information is being disclosed for the following purpose(s).

_____

_____

5. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_____
Signature of Patient or Personal Representative Date

_____
If signed by Personal Representative, relationship to patient

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Patient Authorization to Disclose Protected Health Information, CONTINUED

6. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Mendocino Coast Clinics, Inc., 205 South Street, Fort Bragg, CA 95437. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

   _____ (if left unsigned, then 1 year from the date of this Authorization)

8. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

9. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health care plan if applicable, or eligibility for benefits.

10. I understand that I will be given a copy of this authorization form, after signing.

_____
PRINT NAME

_____
Signature of Patient or Personal Representative Date

_____
If signed by Personal Representative, relationship to patient

_____
Signature of Witness Date Time

The “Personal Representative” is any of the following:

1. For an incompetent adult:
   a. A conservator of the patient’s person
   b. An agent appointed by the patient under a power of attorney for health care
2. For a minor who does not have special legal authority to sign an authorization:
   a. Parent
   b. Guardian
   c. Any other person *in loco parentis*
3. Any other individual who has the legal authority to make health care decisions on the patient’s behalf (e.g., person who is the next-of-kin to a resident in a skilled nursing facility; a person legally obligated to financially support patient); or
4. An executor or administrator of the patient’s estate or any beneficiary who stands to inherit property from the patient, if the patient is deceased.