Mendocino Coast Clinic, Inc.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

**PLEASE COMPLETE ALL SECTIONS, DATE, AND SIGN.**

**I.** I, ______________________________________, hereby voluntarily authorize the disclosure of medical information for:
(Printed Name of Patient)
Patient name___________________________________ DOB ________________ Relation:___________________________

**II. RELEASE:** ☐ **FROM** ☐ **TO** | **RELEASE:** ☐ **FROM** ☐ **TO**

| | |
|---|---|
| NAME OF HEALTH CENTER<br>**Mendocino Coast Clinic, Inc. Attn: Medical Records** | NAME OF PERSON/ORGANIZATION/FACILITY |
| ADDRESS<br>**205 South Street** | ADDRESS |
| CITY/STATE<br>**Ft Bragg, CA 95437-5540** | CITY/STATE |
| **Telephone** **Email** **Fax**<br>**707-694-1251** medicalrecords@mccinc.org **(707) 961-2722** | Telephone Fax |

**III. The purpose or need for this disclosure is:**

☐ Attorney ☐ School ☐ Research
☐ Personal Use ☐ Insurance ☐ Disability ☐ **TRANSFER OF CARE**

**IV. (a) The information to be disclosed from my health record: (initial all appropriate line(s))**

_______ Only information related to *(specify)* :_________________________________________________________________

_______ Only for dates from ________________________________________ to ___________________________________________

***Unless otherwise indicated, only records 2 years prior to this request will be released***

_______ Other (specify) (Dental, Lab, Billing, Teen Clinic, etc.): ___________________________________________________

_______ Medical Record (last 2 yrs.)* *(does not include Sensitive Protected Health Information unless specified below)*

**(b) Sensitive Protected Health Information I authorize to be disclosed, initial the applicable line(s) below:**

_______ Alcohol/Drug Treatment/Referral _______ HIV/AIDS-Related Treatment

_______ Mental Health Notes (by initialing, I am waiving any psychotherapist-patient privilege)

**** Initials Only (checks and X marks will not be accepted)***

**V.**

I understand that I may revoke this authorization in writing submitted at any time to: MCC, Medical Records Department, 205 South St., Ft. Bragg, CA 95437, except to the extent that action has been taken in reliance on this authorization. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it, unless another authorization for such disclosure is obtained from me, or such disclosure is specifically permitted by law. Information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such re-disclosure might not be protected by California law or federal HIPAA law, depending on the circumstances. Confidentiality of Medical Information Act (CMIA) prohibits such re-disclosure without a new written authorization except as specifically permitted or required by law (California Civil Code Subsection 56.13). If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated.

(Specify new date)_____________________________________________

Mendocino Coast Clinics, Inc., its facilities, employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized here in.

| SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE (State relationship to patient) | DATE |
|---|---|
| SIGNATURE OF WITNESS (If signature of patient is a thumbprint or mark) | DATE |

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.

To note: The timeframe for Processing of Medical Record Release may take up to 30-days from signature date.