**Mountain Communities Healthcare District**

**AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide *all* information requested may invalidate this authorization.

Patient Name: (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I AUTHORIZE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Facility or other provider)

**TO DISCLOSE TO**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Persons/organizations authorized to *receive* the information)

At the following address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street, City, State, and Zip or fax number)

(3) Dates of treatment: From (Date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ to (Date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(4) Information disclosed for the purpose of: Medical Care Insurance/Legal Claim

Patient/Personal Other Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(5) Type of information to be released: (Check all applicable categories)

 Medical history, examination report  Discharge summary

 Operation reports  Consultation reports

 Laboratory report  X-ray reports  Pathology reports  Emergency room records

 **Complete** medical record  Clinic Chart Notes

**MY RIGHTS**

* I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits
* I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
* I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

Mountain Communities Healthcare District

P O Box 1229 Weaverville CA 96093

ATTN: Health Information Department

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

* I have the right to receive a copy of this authorization.
* Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not prohibited by California law and may 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 unless such disclosure is specifically required or permitted by law.

**SIGNATURE**  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Patient) or (Legal Representative)

If signed by a person other than the patient, indicate relationship:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Relationship to Patient)

I understand that the information in my health record may include information relating to any of the following:

Sexually transmitted disease,

Acquired Immunodeficiency Syndrome (AIDS),

Human Immunodeficiency Virus (HIV),

Behavioral or mental health services,

Alcohol and/or drug abuse or an employment related drug panel.

Reproductive Health, including gender affirming care, abortion, or contraception

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[**Signature** of Patient or Legal Representative] [**Printed name** of person signing form]

**This** **authorization** **expires in one year, unless otherwise noted below:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FOR QUESTIONS CALL:**

**Trinity Hospital /Health Information** Phone: **530-623-0278** **ext.** **1011** Fax: **530-623-3073**

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