

Authorization to Disclose Health Information

I, the undersigned, authorize (please check applicable clinics) to release my health information as noted below:

- | | | |
|---|--|--|
| <input type="checkbox"/> Clinica Del Alma | <input type="checkbox"/> Keeling Health Center | <input type="checkbox"/> Ortiz Community Health Center |
| <input type="checkbox"/> East Side Health Center | <input type="checkbox"/> Health Center-Main | <input type="checkbox"/> Santa Catalina Health Center |
| <input type="checkbox"/> Flowing Wells Family Health Center | <input type="checkbox"/> MHC Obstetrics & Women's Health | <input type="checkbox"/> West Side Health Center |
| <input type="checkbox"/> Freedom Park Health Center | <input type="checkbox"/> MHC Primary Care Health Center | <input type="checkbox"/> Wilmot Family Health Clinic |

Patient Information

Patient Full Name: _____ Other Names During Treatment? _____
 Patient Address: _____ Date of Birth: _____
 City: _____ State: _____ Zip: _____ Phone #: _____

Release Information To

-This box must be complete in order for request to be processed-

Name/Facility: _____ Attention: _____
 Address: _____ Phone: _____
 City: _____ State: _____ Zip: _____ Fax: _____

Purpose of Request: Personal Treatment Legal Insurance Disability
 Transfer/Reason _____ Other _____

Information to be Released

<input type="checkbox"/> Please provide a 2 year abstract of my records <i>Copy fee \$15.00 flat fee, plus \$0.25 per page</i> <input type="checkbox"/> Please provide my entire medical record for dates: From _____ To _____ <i>Copy fee \$15.00 flat fee, plus \$0.25 per page</i> <input type="checkbox"/> Other - please be specific: include Clinic/Diagnostic treatment type and dates, ED Visit date, and/or Inpatient Dates of Admission.	<p>Comments</p>
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Authorization to Release Protected Information

***Required** - Please check the boxes below, indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Check one *Initial each line below*

I <input type="checkbox"/> DO <input type="checkbox"/> DO NOT want information about *Mental Health released	_____
I <input type="checkbox"/> DO <input type="checkbox"/> DO NOT want information about *HIV Tests & Related Information released	_____
I <input type="checkbox"/> DO <input type="checkbox"/> DO NOT want information about *Alcohol and/or Substance Abuse released	_____
I <input type="checkbox"/> DO <input type="checkbox"/> DO NOT want information about _____ released	_____

"Other sensitive information?"

 Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Patient's Signature _____ **Date:** _____

(Required for all patients 18 years and older. 18 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian _____ **Date:** _____

(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

- This authorization will expire 90 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the health center took before it received the revocation.
- I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.
- I understand that my treatment or continued treatment by MHC Healthcare and its affiliates is in no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.
- I understand that I may inspect or copy the information that is used or disclosed.

FOR INTERNAL USE ONLY EMR Only Paper Chart (scanning completed)

Location _____ Employee _____ Date _____