MORONGO BASIN
COMMUNITY HEALTH CENTER
A SERVICE OF MORONGO BASIN HEALTHCARE DISTRICT

*Phone 760-365-9305 | Fax 760-365-9309*

# AUTHORIZATION FOR USE OF DISCLOSURE OF HEALTH INFORMATION OR PATIENT'S REQUEST FOR ACCESS TO, OR COPY OF PROTECTED HEALTH INFORMATION

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

Patient Name: _____ Date of Birth _____

Medical Records Number: _____ Contact Number: _____

*If you are requesting a copy of your records for your personal use, there may be fees associated with your request. California law (Health and Safety Code Section 123110(b) specifies a charge not exceeding $0.25 per page for copies of medical records. There is no charge to you for the first 15 pages. Page 16 and above will be $0.25 per page. Payment must be made at the time you receive the copies.*

I hereby authorize **MORONGO BASIN COMMUNITY HEALTH CENTER** to release my medical records to:

_____ Phone Number _____

*Name*

_____

*Street Address / City / State / Zip Code*

Method of Transfer: ❑ Mail ❑ Patient pick-up ❑ Fax to _____

Dates of Service: from _____ to _____

This authorization is for full disclosure of all records, including:

- ❑ Healthcare received from dates _____ to _____
- ❑ Medical consultations by Provider _____
- ❑ Recent pertinent medical information only (last 12 months)
- ❑ Recent laboratory test results (last 30 days)
- ❑ Recent X-ray reports (last 30 days)
- ❑ Recent Provider progress notes (last 30 days)
- ❑ Other, please specify: _____

If you are requesting access to records relating to any of the following, **please initial each item** to confirm your request. These classes of information are protected by special privacy laws and access may be subject to special rules or may be restricted under certain circumstances. A separate authorization is required to permit the disclosure or use of psychotherapy notes.

_____ HIV / AIDS test results (requires approval by your physician)

_____ Psychological care (requires written approval by your psychologist or social worker)

_____ Records regarding alcohol or drug abuse treatment

The above information is released for the following purpose and that purpose only:

- ❑ Personal request
- ❑ Insurance purposes
- ❑ Continuation of care
- ❑ Employment / Military requirement
- ❑ Legal purposes
- ❑ Other: _____

This Authorization expires (date) _____

-------- *OVER*-------

| | |
|---|---|
| **Right to Revoke** | I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and submit it to the following address:<br>**MORONGO BASIN COMMUNITY HEALTH CENTER, attention Medical Records**<br>**6530 La Contenta Road, suite 100, Yucca Valley CA 92284.**<br>I understand that the revocation will not apply to information that has already been released based on this authorization. |
| **Expiration** | Unless otherwise revoked, this authorization will expire on the listed date. If I do not specify an expiration date, event, or condition, this authorization will expire one year from signature. |
| **Re-disclosure** | 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 the federal confidentiality law (HIPAA). However, California law prohibits the person receiving my6 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. |
| **Other Rights** | I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment. I also understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CRF 164.524. I have the right to receive a copy of this authorization. If I have any questions about disclosure of my health information, I can contact the Privacy Officer at 760-820-9229. |

All requests for copies of medical records or other protected health information are processed in the order they are received. It may not be possible to provide to you the requested information at the time of your request. If we are not able to process your request immediately, please allow 7-10 business days to process the request. We will contact you by phone when the requested information is available.

**I have read and confirm the terms of access stated herein.**

Signature of Patient
or Legal Representative _____ Date _____

If signed by someone other than the patient, indicate relationship _____

Print name of Legal Representative _____

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*FOR INTERNAL PROCESS*

*Name of staff person who verified identification of patient / representative:* _____

Name of Provider: _____ ❑ physician ❑ psychologist ❑ psychiatrist ❑ LCSW

I hereby ❑ approve ❑ disapprove the release of information and records to the patient or legal representative specified herein. NOTE: If disclosure is disapproved, give reasons and note any restrictions to the release of information.

_____

_____

Provider's
Signature _____ Credential _____ Date _____