North Coast Family Health Center
A Department of Mendocino Coast District Hospital
Ste A: (707) 961-4631; Fax (707) 964-1192; Ste B: 964-6910; Fax 964-7430; Ste C: 961-4995; Fax 962-9481

I hereby authorize the following party to release health information to Mendocino Coast District Hospital: (you are requesting information from that provider/facility)

Provider _____ Phone_____

Address_____

Patient Name_____ Birthdate_____

Address_____ Phone_____

PURPOSE OF RELEASE: [ ] Medical care [ ] _____

INFORMATION YOU AUTHORIZE TO BE RELEASED: (Be specific)

Type:_____

Treatment dates:_____

INFORMATION NOT RELEASED unless specifically authorized by initialing the relevant line(s) below:

____ **HIV**: I specifically authorize release of HIV test results (Health and Safety Code Section 20980(g)) for which I have already received counseling.

____ **Hereditary Disorder Tests**: I specifically authorize release of Hereditary Disorder test results (antenatal, neonatal, childhood or adult hereditary disorder screening), and have read the cautionary notes attached on the back of this form (Health and Safety Code Section 124980).

____ **Authorization Expiration:** Unless otherwise revoked this authorization expires _____. (If no date is indicated, the authorization will expire 12 months after I sign this form.)

Your Privacy Rights: You may refuse to sign this authorization. Your refusal won't affect your ability to obtain treatment, insurance payment or eligibility for benefits. You have the right to withdraw or revoke this authorization in writing at any time, except when MCDH has already released the information. To withdraw/revoke your authorization, please submit your request in writing to Mendocino Coast District Hospital, Medical Records, 700 River Dr, Fort Bragg, CA 95437.

SIGNATURES:

_____ _____ _____ _____
Signature (Patient/personal representative*) Print Name Date Time

_____ _____ _____
*Indicate Relationship to Patient Witness Signature Print Name

A COPY OF THIS AUTHORIZATION **MUST** BE GIVEN TO REQUESTOR IF REQUESTED BY A COVERED ENTITY

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION to M.C.D.H.
8700-MCDH- (6/20/12)

INSTRUCTION FOR COMPLETION OF AUTHORIZATION TO RELEASE MEDICAL INFORMATION

When you complete and sign this form, health information about you will be released as you describe in the form. Please read each section carefully and complete the required sections before signing. We encourage you to request a copy of your records and review them before authorizing the release of the records to someone other than you. Please clearly and legibly print all information when completing this form and sign under "SIGNATURES."

Charges: There is no charge for information released for purposes of medical care. A fee of 10 cents/page and $4.00 per quarter hour is charged for copies for other purposes. Please contact **707-961-4626** for additional information.

Cautions Before Signing:

1. Health care providers are required by law to keep your health information confidential. However, your health information that will be released as a result of you signing this authorization could be re-disclosed by the recipient. If this occurs, your re-disclosed health information may no longer be protected by state or federal privacy law.
2. We encourage you to request a copy of your records and review them before authorizing the release of the records to someone other than you.
3. The release of this information may involve certain risks, such as re-disclosure by the recipient, loss or compromise of insurance benefits, or employment status.
4. If you have questions about this authorization form or the release of your health information, please contact Mendocino Coast District Hospital Medical Records Department at **707-961-4626** before signing this form.

Releasing records to:

1. Please provide the name of the patient whose records are being requested for release. 2. Please provide the facility name or name of person whom you authorize to receive the health information indicated on this form. Please note: if you wish to impose restrictions on the recipient's use of the health information, you must contact the recipient directly.

Purpose of Release: Please indicate the reason you would like your health information released, if other than your request (as the patient) for your own records for your own care follow-up.

Information You Want Released: Please describe the specific health information you would like released. Certain specific health information requires a separate indication from you in order for us to release that information, such as HIV test results and hereditary disorder test results—if you do not initial those lines that information will not be included in the release.

Please indicate / describe if: (1) You would like information related to specific dates of service released, and not the entire medical record; (2) You would like a specific type of health information released, e.g. only a report of your surgery or a CAT scan report; (3) You would like your entire medical record released, or (4) You would like your billing records released.

HIV Lab Test Results: Initial line for HIV tests if you had HIV tests performed and would like the HIV test results released.

Hereditary Disorder Test Results: Initial the line for Hereditary Disorder Tests if you had Hereditary Disorder tests performed and you would like the Hereditary Disorder test results released. Hereditary Tests include antenatal, neonatal, childhood and adult hereditary disorder screening records (genetic screening). The release of this information may involve the following risks: re-disclosure by the recipient of Hereditary Disorder test results, loss or compromise of insurance benefits, or employment status. The release of this information may involve the following benefits: predetermination of genetic conditions, coordination of care, treatment options. You should consult your physician concerning the risk and benefits of specific tests.

Expiration of This Authorization: This authorization becomes effective when you sign it, and if you do not give a date for its expiration, the authorization will expire one (1) year from the signature date.

Signature of Person Authorizing Release: Please sign and date the authorization, providing your printed name in addition to your signature. If you are not the patient and you are signing this authorization form, describe your authority to sign on behalf of the patient and please provide supporting legal documentation (unless you are the parent signing for a minor child).

Copy of This Authorization: You have the right to receive a copy of this information. We are required to give you a copy of this authorization if it is being requested by an insurer or other HIPAA covered entity.

How You Want This Information Sent to Recipient: We will return information in the same manner in which the request is received, e.g. handed to you personally, mailed back or returned by fax, unless you notify us otherwise.

Inspection of Records: If you are not requesting a copy of your health information but would like to inspect your records, please specify this and we will contact the Director of Quality Management to make appropriate arrangements for inspection. Mendocino Coast District Hospital may deny your request to inspect and/or receive a copy of your health information under certain circumstances as authorized by law. You will be notified of any such denial and of how you may appeal such denial.

***Personal Representative:** May be a conservator of an incompetent person, an agent appointed by the patient under power of attorney for health care, parent or guardian of a minor child (or any other person *in loco parentis*), an executor/administrator of a deceased patient's estate or beneficiary who stands to inherit property from the patient, or other person with legal authority to make healthcare decisions on the patient's behalf (next-of-kin in a SNF or person legally obligated for financially support.