MACT Mariposa Amador Calaveras Tuolumne HEALTH BOARD INC

A Non-Profit Tribal Corporation

Authorization for Use or Disclosure of Protected Health Information

Section 1. Instructions

Return completed forms and supporting documentation to:

Mail: MACT Health Board, Inc.
Health Information Management
PO Box 939
Angels Camp, CA 95222

Fax: (209) 674-6200
Email: medical.records@macthealth.org
Phone: (209) 754-6262

Section 2. Patient's Information

Patient's Name: _____

Date of Birth: _____

Patient's Address:

_____

_____

Patient's Telephone: _____

Patient's Email: _____

Section 3. Release Information [45 CFR 164.508(c)(1)(ii) and (iii); CA Civil Code 56.11(e) and (f)]

Person/Organization Providing the Information

Name: _____

Mailing Address:

_____

_____

Phone: _____

Fax: _____

Email:

Person/Organization to Receive the Information

Name: _____

Mailing Address:

_____

_____

Phone: _____

Fax: _____

Email:

Section 4. Purpose for this Release

☐ Personal use ☐ Transition of care ☐ Insurance ☐ Disability
☐ Further medical care ☐ Attorney ☐ School ☐ Research

☐ Other: _____

Section 5. Information to be Disclosed [45 CFR 164.508(c)(1)(i); CA Civil Code 56.11(d) and (g)]

The information to be disclosed from my health record include:

☐ Entire record including (select all that apply): ☐ Medical ☐ Dental ☐ Behavioral Health ☐ Billing

☐ Only information related to (specify):

☐ Only the period of events from _____ to _____

☐ Billing information from _____ to _____

☐ Labs from _____ to _____

☐ Dental x-rays from _____ to _____

☐ Other:

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/drug abuse treatment/referral

☐ HIV/AIDS-related treatment

☐ Sexually transmitted infections

☐ Mental health (other than psychotherapy notes)

☐ Psychotherapy notes. I understand I am waiving any psychotherapist-patient privilege: _____
Initials

Section 6. Fees for Releasing Information [45 CFR 164.524(c)(4)]

Reasonable fees associated with this request will be charged for: (1) labor, (2) supplies, (3) postage, and (4) preparation of an explanation or summary, if applicable.

I understand I will be billed for this request: _____
Initials

Section 7. Expiration Date of this Request [45 CFR 164.508(c)(v); CA Civil Code 56.11(h)]

This authorization for the release of the above information to the above named person or organization will expire one (1) year from the date signed unless the authorized individual completing this request states a specific expiration date.

☐ This request expires in one (1) year from the date signed.

☐ This request expires on the following date: _____

Section 8. Acknowledgements and Authorization

I understand that:

- I authorize the use and/or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary. [45 CFR 164.508(c)(2)(i]
- I have the right to revoke this authorization at any time by sending a signed notice stopping this authorization to:

  MACT Health Board, Inc.
  Privacy Office
  PO Box 939
  Angels Camp, CA 95222

  The authorization will cease on the date my valid revocation request is received. [45 CFR 164.508(c)(2)(i); CA Civil Code 56.15]
- The Notice of Privacy Practices provides instruction for me should I choose to revoke my authorization and includes limitations on my revocation. [45 CFR 164.508(c)(2)(i)]
- My treatment, payment, enrollment or eligibility for benefits will not be affected if I do not sign this authorization. [45 CFR 164.508(c)(2)(ii)]
- Under California law, the recipient of my medical information is prohibited from redisclosing the information, except with a written authorization or as specifically required or permitted by law. [CA Civil Code 56.13]
- If the organization or person I have authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. [45 CFR 164.508(c)(2)(iii)]
- I have the right to receive a copy of this authorization. [45 CFR 164.508(c)(4); CA Civil Code 56.11]
- Records and copies obtained relating to outpatient psychotherapy care shall be returned or destroyed at the expiration date of this authorization except those obtained for treatment and diagnosis purposes. [CA Civil Code 56.104(a)(4)]

_____	_____	___/___/____	_____
Print Name of Patient	Signature of Patient	MM DD YYYY	Relationship to Patient
_____	_____	___/___/____	_____
Print Name of Authorized Representative	Signature of Authorized Representative[1]	MM DD YYYY	Relationship to Patient

[1]If this form is completed and signed by an authorized representative, supporting legal documentation is required.