

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

YOU HAVE THE RIGHT TO RECEIVE A COMPLETED COPY OF THIS FORM. PHOTOCOPY/FAX COPY MAY BE USED AS ORIGINAL.

NOTE TO CLIENT: A FEE MAY APPLY TO THIS REQUEST FOR RECORDS.

CLIENT(PATIENT) INFORMATION:

¹ NAME: _____
Last First MI

² AKA: _____

³ SSN: _____ ⁴ BIRTHDATE: _____

I, the undersigned, hereby authorize the ⁵ Disclosure ⁶ Exchange ⁷ Request of the following Protected Health Information (PHI):

PHI From:

Disclose PHI to:

^{8A} Name of Facility Producing Records _____

^{9A} Person/Agency _____

^{8B} Street Address/Mailing Address _____

^{9B} Street Address _____

^{9C} Phone Number _____

^{8C} City, State, Zip _____

^{9D} City, State, Zip _____

An authorization to disclose PHI is voluntary. Treatment, payment or eligibility for benefits will not be affected if you do not sign this authorization. Redisclosure of a person's PHI is prohibited without the specific written authorization of that person or as otherwise permitted by state or federal law. Information disclosed pursuant to this authorization may be disclosed by the recipient and no longer be protected by California or federal law.

PHI TO BE DISCLOSED: (Please initial all that apply and identify clinic and time period as necessary.)

- ¹⁰ Summary of PHI _____
- ¹¹ Mental Health PHI / Psychotherapy Notes Clinic where treated and when: _____
- ¹² Alcohol/Substance Abuse Treatment PHI Clinic where treated and when _____
 - ^{12A} Urine Tests ^{12B} Progress in Treatment ^{12C} Dates of Attendance
- ¹³ Medical Record PHI Clinic where treated and when: _____
 - ^{13A} California Children's Services ^{13B} Pulmonary/TB ^{13C} Lab/Test Results ^{13D} STD Treatment
 - ^{13E} Child Health/Immunization Records ^{13F} Maternal Health ^{13G} Dental Care
 - ^{13H} X-ray of _____ ^{3H1} Results ^{13H2} Films ^{13I} Other _____
- ¹⁴ HIV Results/AIDS Treatment PHI _____

PURPOSE OF THE DISCLOSURE OF PHI:

(e.g., The request of the Individual, continuity of care, attorney access, court case, insurance, disability, etc.)

UNLESS OTHERWISE REVOKED IN WRITING, THIS AUTHORIZATION EXPIRES ON :

^{16A} Completion of this request (one time disclosure). ^{16B} Six Months from signature date below.

^{16C} Expires as specified: _____

You may revoke this authorization in writing at any time by sending a notice to the Custodian of Records. The authorization will stop on the date received, except if action has been taken in reliance on it.

TODAY'S DATE: _____

SIGNATURE: _____

¹⁹ PRINTED NAME: _____

²⁰ RELATIONSHIP: _____

²¹ COMPLETE ADDRESS _____
Street Address City State Zip Code

²² TELEPHONE #: _____ () _____

Please return the completed verification for processing to the MMIC Program, 1200 N Main St #100-A Phone (714) 480-6717; Fax (714) 480-6656