Behavioral Health and Recovery Services

Jenine Miller, Psy.D., Director Health Services

Providing Mental Health and Substance Use Disorders Treatment Services

***Ukiah Offices*: 1120 S. Dora St. • Ukiah • CA • 95482 • (707) 472-2300 • FAX (707) 472-2306**
***Fort Bragg Offices*: Avila Center • 790-B S. Franklin St. • Fort Bragg • CA • 95437 • (707) 961-2665 • FAX (707) 961-2698**
***Willits Integrated Services Center*: 474 E. Valley St. • Willits • CA • 95490 • (707) 456-3850 • FAX (707) 456-3808**

AUTHORIZATION FOR USE, EXCHANGE AND/OR DISCLOSURE OF CONFIDENTIAL HEALTH AND PERSONAL INFORMATION

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Name of Patient: _____

Date of Birth: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: _____ to release to *(initial)*: ____

___ Primary Care Provider: _____
(Name & address – street, city, state, zip code)

___ Therapist/Org Provider: _____
(Name & address – street, city, state, zip code)

___ Hospital: _____
(Name & address – street, city, state, zip code)

___ Psychiatrist: _____
(Name & address of agency authorized to receive records)

___ Law Enforcement: _____
(Name & address of agency authorized to receive records)

___ Mendocino County Sheriff's Office: 951 Low Gap Road, Ukiah, CA 95482

___ Mendocino County District Attorney: _____, 100 North State Street, Rm. G-10, Ukiah, CA 95482.
(Name of attorney)

___ Mendocino County Probation: _____, 589 Low Gap Road, Ukiah, CA 95482. *(Name of officer)*

___ Mendocino County Superior Court: Hon._____ , 100 North State Street, Ukiah CA 95482. *(Name of Judge)*

___ Mendocino County Public Defender: _____, 175 S. School Street, Ukiah CA 95482. *(Name of attorney*)

___ NaphCare, Jail Medical Services: 951 Low Gap Road, Ukiah, CA 95482.

___ Substance Use Disorder Treatment (SUDT): 1120 S. Dora St, Ukiah CA 95482.

___ Child Welfare Services: 727 S. State St. Ukiah 95482

___ Redwood Community Services: 631 South Orchard Avenue, Ukiah, CA 95482

___ Anchor Health Management, Inc.: 531 South Orchard Avenue, Ukiah, CA 95482

___ Mendocino Coast Hospitality Center: 101 N. Franklin St., Fort Bragg, CA 95437

___ Redwood Coast Regional Center (RCRC): 1116 Airport Park Blvd. Ukiah 95482

___ Family Member / Support Person_____
(Name & relationship)

_____
(Address – street, city, state, zip code)

___ _____

_____
(Other organization(s) or person(s) authorized to receive information, including address – street, city, state, zip code)

___ I authorize exchange of information between the above parties for the following information:

(must initial choices):

a. ____ All health information pertaining to my medical history, mental or physical condition, and treatment received during time period *(optional)*_____;

OR

____ Only the following records or types of health information (including any dates):

_____

_____

_____

b. I specifically authorize release of the following information (this information will not be released unless specifically authorized) *(initial)*:

____ Mental health treatment information

____ HIV test results (Health & Safety Code § 120980(g))

____ Alcohol/drug treatment information (42 C.F.R. §§ 2.34 & 2.25)

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

PURPOSE

Purpose of requested use or disclosure: Patient request; OR Other:

_____

_____

EXPIRATION

This authorization expires one year from the date of signature or on the following date: _____

MY RIGHTS

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: Mendocino County Behavioral Health and Recovery Services, 1120 S. Dora Street, Ukiah, CA 95482, Attn: Medical Records.
My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

I have a right to receive a copy of this authorization.

Information disclosure pursuant to this authorization could be re-disclosed by the recipient. Such disclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosures of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNATURE

Date: _____ Time:_____ AM/PM

Signature: _____

(patient/legal representative)

If signed by other than patient, indicate

Relationship: _____

Print Name: _____