Mendocino County Health and Human Services Agency
"Healthy People, Healthy Communities"
Tammy Moss Chandler ❖ Director
Jenine Miller ❖ Behavioral Health Director

Behavioral Health and Recovery Services
Providing Mental Health 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: Mendocino County Behavioral Health, 1120 S. Dora St. Ukiah, 95482 to release to *(initial)*:

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

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

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

___ GEO Re-entry Services: _____, 579 Low Gap Road, Ukiah, CA 95482.

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

___ Mendocino County Substance Use Disorder Teatment (SUDT): 1120 S. Dora St., Ukiah 95482

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

___ 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)

___ California Forensic Medical Group: Claire Teske, 951 Low Gap Road, Ukiah, CA 95482.

___ _____

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

___ I authorize exchange of information between the above parties.

The following information *(initial)*:

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 on one year from the date of signature or on the following date or event: _____

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 D. 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 redisclosed 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 disclosure 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: _____