mha Mental Health Association of Orange County
Since 1958

AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

Fees may apply to certain requests

FOR OFFICE USE ONLY

1) CLIENT/PATIENT NAME: _____

OTHER NAMES USED: _____ BIRTH DATE: _____

SSN: (*LAST 4 DIGITS*) _____ MRN: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ PHONE #: (____) _____

An authorization to use and disclose PHI is voluntary. Treatment, payment or eligibility for benefits will not be affected if you do not sign this authorization. This disclosure is made at your request. A copy of the original authorization is valid. You have a right to a copy of this completed authorization.

I authorize **Mental Health Assoication of Orange County** to release my health information to:

2) Individual Name or Organization: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone #: (_____) _____

3) Purpose(s) of Use and/or Disclosure: ☐ Request by Patient for Patient or Designee Use Only

☐ Continuity of Care/Medical Treatment ☐ Insurance ☐ Legal ☐ Disability ☐ Other: _____

4) Date range of records to be released:

Clinic(s) where treated:

5) PHI to be disclosed:

☐ Lab/Test Results	☐ WIC	☐ Medical Record PHI	☐ Summary of PHI
☐ Maternal Health	☐ Pulmonary/TB	☐ AMM/MSN/MSI	☐ Child Health/Immunization Records
☐ STD Treatment	☐ Dental Care	☐ X-ray Films	☐ California Children's Services (CCS)
		☐ X-ray Results	☐ Other: _____

Your initials are required to release the following information:

☐ Drug, Alcohol, or Substance Abuse Records/Results/Treatment ☐ Mental Health Records ☐ HIV/AIDS Records/Results

EXPIRATION: This authorization expires upon completion of this request.
REVOCATION: You may revoke this authorization in writing at any time by sending a notice to the Custodian of Records. The revocation will not be effective if the Custodian has already taken action in reliance on the authorization.
REDISCLOSURE: Information disclosed pursuant to this authorization may be disclosed by the recipient and no longer be protected by federal privacy law (HIPAA). Applicable State or other federal law may require recipient to obtain your written authorization before re-disclosure unless otherwise permitted by such laws.
NOTICE OF REDISCLOSURE OF ALCOHOL AND DRUG ABUSE INFORMATION TO RECIPIENT: This information disclosed to you is protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from re-disclosing this information unless it is expressly permitted by the written consent of the patient or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____ _____

6) Date 7) Signature If Personal representative, print name/relationship

*All numbered items must be completed for authorization to be valid

Please return completed form for processing to: MHA Custodian of Records ● Fax (714) 640-5768
822 Town and Country Rd, Orange CA 92868 ● Phone (714) 547-7559 ● Website: http://www.mhaoc.org