

AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

FOR OFFICE USE ONLY	PART 1: CLIENT/PATIENT INFORMATION			
	Client/Patient Last Name	Client/Patient First Name	Middle Initial	
	Other Names Used	Date of Birth	SSN (Last 4 Digits)	MRN (If known)
	Email:		Telephone Number with area code:	
	Address	City	State	Zip

PART 2: THE MENTAL HEALTH ASSOCIATION MAY DISCLOSE THIS INFORMATION TO: **Check if same as above**

Name of Person or Organization	Address
General Designation (For 42 CFR Programs only)	
City	State
Zip	Telephone Number with area code

PART 3: PURPOSE OF THIS AUTHORIZATION

Patient Request
 Continuity of Care/Medical Treatment
 Insurance
 Legal
 Disability
 Other:

PART 4: INFORMATION THAT CAN BE RELEASED (Steps 1, 3, and 4 required. Complete step 2 for specificity)

Step 1. Select one only: Medical Records Summary of Treatment

Step 2. Select types of records to be released:

<input type="checkbox"/> Family Health	<input type="checkbox"/> STD Treatment	<input type="checkbox"/> California Children's Services (CCS)
<input type="checkbox"/> X-ray Results/Films	<input type="checkbox"/> Pulmonary/TB	<input type="checkbox"/> WIC <input type="checkbox"/> Immunizations
<input type="checkbox"/> AMM/MSN/MSI	<input type="checkbox"/> Dental Care	<input type="checkbox"/> Other:

Your *initials and date range* of records to be released are **required** below for use or release of the following types of sensitive information or records:

Alcohol, Drug or Substance Abuse Records**	Date From:	Date To:
Mental Health	Date From:	Date To:
HIV/AIDS Testing and Results	Date From:	Date To:

Step 3. Clinic(s) where services were received:

Step 4. Delivery Preference: Electronic Mail Pickup

FOR YOUR REVIEW

I have read the contents of this form. I understand, agree, and allow the Mental Health Association to use and release my information as I have stated above. I also understand that signing this form is voluntary and treatment, payment or eligibility for benefits will not be affected if I do not sign this authorization. I have the right to revoke this authorization at any time in writing by sending a notice to the Custodian of Records. The revocation will not affect disclosures the Custodian has already taken action in reliance on the authorization. Information disclosed pursuant to this authorization may be re-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. I am entitled to a copy of this form. Fees may apply to certain requests. A copy of the original authorization is valid. This authorization expires upon completion of this request.

PART 5: Client/Patient Signature or Designated Legal Representation/Guardian Signature	PART 6: Date
X	
Legal Representative (print full name)	Legal relationship to client/patient

**** ALCOHOL AND SUBSTANCE ABUSE INFORMATION**
 42 CFR part 2 prohibits unauthorized disclosure of these records.

Please return completed form for processing to: MHA Custodian of Records • 1971 E. 4th St., Suite 130A, Santa Ana, CA 92705 • Phone (714) 547-7559 • FAX (714) 242-7306 • Website: <https://mhaoc.org/services/>