Authorization for Use or Disclosure of Mental Health Information

Community Memorial HEALTHCARE

Patient's Name _____ Birth Date _____ MR# _____ Bill # _____

Address _____ City _____ State _____ Zip Code _____

Phone(s) _____ E-Mail _____

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information.

Failure to provide all information requested may invalidate this authorization.

NOTICE OF RIGHTS AND OTHER INFORMATION

1. I understand that this authorization is voluntary.
2. I may refuse to sign this authorization.
3. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this authorization. I understand the Notice of Privacy Practices provides instruction should I choose to revoke my authorization.
4. Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.
5. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might 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.
6. I may inspect or obtain a copy of the health information that I am being asked to use or disclose.
7. If this box ☐ is checked, the requestor will receive compensation for the use or disclosure of my information.
8. I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to: **Community Memorial Healthcare, Health Information Department, 147 North Brent Street, Ventura, CA 93003.**
9. I understand that I have the right to choose how I am to receive my health information.
   a. Please choose a mode of delivery (choose one option)
      ☐ 1. Mail (address listed below): ☐ Paper ☐ CD ☐ Flash Drive (electronic file will be in "pdf" format)
      ☐ 2. Secure email to (email of recipient below) _____
      ☐ 3. Fax records to (fax# of recipient, example: patient or legal representative) _____
      ☐ 4. In-person: ☐ Paper ☐ CD ☐ Flash Drive
   b. Please be advised that with utilizing fax or secure e-mail, there is some level of risk that your requested-health information could be read or otherwise accessed by a third party while in transit.
   c. Per Community Memorial Healthcare policy and procedure, fees may be applied per fee schedule.
10. I understand I have the right to receive a copy of this authorization (Civ. Code § 56.12). Per Community Memorial Healthcare policy and procedure, an ID may be requested to verify identity of the patient, spouse or designated representative.

I hereby authorize Community Memorial Hospital(s) ☐ Ventura ☐ Ojai ☐ Community Memorial Health Center(s)/ Services Location (please specify location(s)): _____ to release the requested health information documented in this authorization to:

_____

(PERSON(S) / ORGANIZATION(S) AUTHORIZED TO RECEIVE THE INFORMATION)

Address _____ City _____ State _____ Zip Code _____

LGL813

PLEASE SEE BACK FOR MORE INFORMATION.

This authorization applies to mental health information for the visit date(s) of service/encounter(s) listed below.
Documented by below listed resident/treating mental health clinician or attending mental health clinician.

Date(s) of visit(s) service/encounter(s) _____

Resident or treating clinician(s) _____

Attending clinician(s) _____

Mental health information requested ☐ Behavioral Health Notes

If a copy or access is denied, notification will be provided to the patient or patient's legal representative in writing.

For Office Use Only

Approved ☐ Yes ☐ No

Print clinician/designated mental health leadership name _____

Signature _____ **Date** _____ **Time** _____ **AM / PM**

PURPOSE

Description of each purpose of request use or disclosure _____

EXPIRATION

This is a one time use mental health authorization and is not to be utilized for any dates of service past the date of the authorization.

SIGNATURE

If signed by someone other than the patient, state your legal relationship _____
If patient's legal representative, please provide supporting documentaion such as power of attorney, death certificate, court order or advance directive. If patient has expired, provide proof of conservatorship, proof of custody or court order.

Patient/spouse/designated legal representative

Print name _____

Signature _____ Date _____ Time _____ AM / PM

For Office Use Only

☐ ID checked

Hospital representative processing request _____

Date _____

Community Memorial Healthcare-Ventura ~ Medical Records/Health Information Department ~ 147 North Brent Street, Ventura, CA 93003
Phone 805-948-5047 ROIrequests@cmhshealth.org Fax 805-652-5649

Community Memorial Healthcare-Ojai ~ Medical Records/Health Information Department ~ 1306 Maricopa Hwy., Ojai, CA 93023
Phone 805-640-2215 Fax 805-640-1649

Community Memorial Health Centers ~ Medical Records/Health Information Department

Please use Community Memorial Healthcare contact information above.
Phone 805-948-5047 Fax 805-652-5649