A Service of Dignity Health Medical Foundation
Mercy Medical Group

1792 Tribute Road, Suite 350
Sacramento, CA 95815

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (BEHAVIORAL MEDICAL RECORD)

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

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Name of Patient:_____ Date of Birth:_____

Other Names:_____ Telephone Number:_____

Medical Record or Account #:_____
(Medical Office use only)

I AUTHORIZE: Dignity Health Medical Foundation/Mercy Medical Group
(Facility or other provider)

TO DISCLOSE TO:_____
(Persons/organizations authorized to ***receive*** the information)

at the following address:_____
(Street, city, state and zip code)

the following information contained in the records specified below (check box and initial applicable lines below):

_____ Mental health or developmental disability treatment records (excludes "psychotherapy notes")

_____ Substance abuse treatment records

_____ HIV test results (This authorizes disclosure of laboratory test results only. **Note that your records may include information concerning your HIV status <u>even</u> if you do not check this box.)**

❑ **THE FOLLOWING RECORDS,** specific types of health information, or records for the date(s) of treatment as specified:

☐ Billing Records	☐ Emergency Room Reports	☐ Procedure Reports
☐ Consultation Reports	☐ History and Physical	☐ Progress Notes
☐ Discharge Summary	☐ Laboratory Tests	☐ X-Ray Reports

☐ Other:_____

❑ **ALL RECORDS** regarding my treatment, hospitalization, and outpatient care. A separate authorization is required for the use or disclosure of psychotherapy notes or research health information.

PURPOSE: The purpose and limitations (if any) of the requested use or disclosure is:

☐ At the request of the patient or personal representative; *OR*
☐ Other:

_____

EXPIRATION: This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified: _____
(Insert Date, on which you want to revoke this authorization)

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 revoke this authorization at any time, but I must do so in writing and submit it to the following address***: Mercy Medical Group Behavioral Health Department, 1792 Tribute Road, Suite 350, Sacramento, CA 95815***. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA). If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R. part 2.

SIGNATURE:_____ Date:_____
(Patient or personal representative)

_____ _____
Print name of personal representative Relationship to patient

Patient/Representative Identification Verified. *Initials:*_____ *Dept:*_____

Note: If the substance abuse treatment information is protected by federal confidentiality rules (42 C.F.R. part 2) the following prohibition of re-disclosure statements must be provided to the recipient of the information:

The federal rules prohibit the recipient from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 C.F.R. 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.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PSYCHOTHERAPY NOTES

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PSYCHOTHERAPY NOTES DEFINITION: Notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record.

Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. (45 CFR 164.501)

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USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Name of Patient:_____ Date of Birth:_____

Other Names:_____ Telephone Number:_____

Medical Record or Account #:_____

I AUTHORIZE: Dignity Health Medical Foundation/Mercy Medical Group
(Facility or other provider)

TO DISCLOSE TO:_____
(Persons/organizations authorized to ***receive*** the information)

at the following address:_____
(Street, City, State and Zip Code)

the following information (check applicable boxes below):

- ❑ All psychotherapy notes pertaining to me.
- ❑ Only the psychotherapy notes on the date(s) of treatment as specified:

_____

PURPOSE: The purpose and limitations (if any) of the requested use or disclosure is:

- ❑ At the request of the patient or personal representative; ***OR***
- ❑ Other: _____

EXPIRATION: This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified:_____
(Insert Date, on which you want to revoke this authorization)

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 revoke this authorization at any time, but I must do so in writing and submit it to the following address: ***Mercy Medical Group Behavioral Health Department, 1792 Tribute Road, Suite 350, Sacramento, CA 95815*****.** My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA). If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R. part 2.

SIGNATURE: _____ Date: _____
(Patient or Personal Representative)

_____ _____
Print Name of Personal Representative Relationship to Patient

Patient/Representative Identification Verified: *Initials:*____ *Dept:*_____

Note: If the **substance abuse treatment** information is protected by federal confidentiality rules (42 C.F.R. part 2) the following prohibition of re-disclosure statements must be provided to the recipient of the information:

The federal rules prohibit the recipient from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 C.F.R. 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.