



**Mendocino Coast Clinics, Inc.**  
**205 South Street, Fort Bragg, CA 95437**  
**707-964-1251**  
**medicalrecords@mccinc.org**

**Patient Authorization to Disclose Protected Health Information**

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

1. I authorize the following individual or Organization to disclose the above-named individual's health information as described below. Please note that MCC releases this information electronically via secure, encrypted messaging.

**Release Information From:**

Mendocino Coast Clinics, 205 South St., Fort Bragg, CA 95437  
 Other (Specify facility/individual & address below, include phone/fax if known.)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Release Information To:**

Mendocino Coast Clinics, 205 South St., Fort Bragg, CA 95437  
 **Adult Fax:** 707-961-2722     **Pediatric Fax:** 707-964-6274  
 **OB Fax:** 707-961-3471     **Email:** medicalrecords@mccinc.org  
 Other (Specify facility/individual & address below, include phone/fax if known.)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. The type and amount of information to be used or disclosed is as follows (check off the appropriate item(s), and include other information, where indicated):

- |   |   |
|---|---|
| <input type="checkbox"/> Entire Record                    | <input type="checkbox"/> Consultation reports from (please supply doctors' names) _____ |
| <input type="checkbox"/> Immunization Record              | <input type="checkbox"/> Dental Clinic Records  |
| <input type="checkbox"/> Most recent history and physical | <input type="checkbox"/> Dental X-ray Films   |
| <input type="checkbox"/> Laboratory results               | <input type="checkbox"/> Mental Health Counseling/Drug & Alcohol Counseling             |
| <input type="checkbox"/> X-Ray and/or imaging             | <input type="checkbox"/> Other (please describe) _____                                  |
| <input type="checkbox"/> Visit Notes                      |   |

3. My authorization pertains to information generated on the following date(s) or in the following time period:  
 \_\_\_\_\_

4. This information is being disclosed for the following purpose(s).  
 \_\_\_\_\_  
 \_\_\_\_\_

5. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

\_\_\_\_\_  
 Signature of Patient or Personal Representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 If signed by Personal Representative, relationship to patient



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<b>Patient Authorization to Disclose Protected Health Information, CONTINUED</b>
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6. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Mendocino Coast Clinics, Inc., 205 South Street, Fort Bragg, CA 95437. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
  
7. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:  
 \_\_\_\_\_ (if left unsigned, then 1 year from the date of this Authorization)
  
8. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.
  
9. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health care plan if applicable, or eligibility for benefits.
  
10. I understand that I will be given a copy of this authorization form, after signing.

\_\_\_\_\_  
 PRINT NAME

Signature of Patient or Personal Representative	Date
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\_\_\_\_\_  
 If signed by Personal Representative, relationship to patient

Signature of Witness	Date	Time
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The "Personal Representative" is any of the following:

1. For an incompetent adult:
  - a. A conservator of the patient's person
  - b. An agent appointed by the patient under a power of attorney for health care
  
2. For a minor who does not have special legal authority to sign an authorization:
  - a. Parent
  - b. Guardian
  - c. Any other person *in loco parentis*
  
3. Any other individual who has the legal authority to make health care decisions on the patient's behalf (e.g., person who is the next-of-kin to a resident in a skilled nursing facility; a person legally obligated to financially support patient); or
  
4. An executor or administrator of the patient's estate or any beneficiary who stands to inherit property from the patient, if the patient is deceased.