



Mendocino County Health and Human Services Agency

"Healthy People, Healthy Communities"

Stacey Cryer ❖ Director

Tom Pinizzotto ❖ Assistant Director



Behavioral Health and Recovery Services

Providing Mental Health Services

Ukiah Offices: 1120 S. Dora St. • Ukiah • CA • 95482 • (707) 472-2300 • FAX (707) 472-2306

Fort Bragg Offices: Avila Center • 790-B S. Franklin St. • Fort Bragg • CA • 95437 • (707) 964-4747 • FAX (707) 961-2698

Willits Integrated Services Center: 221-B S. Lenore Ave • Willits • CA • 95490 • (707) 456-3850 • FAX (707) 456-3808

AUTHORIZATION FOR USE, EXCHANGE AND/OR DISCLOSURE OF CONFIDENTIAL HEALTH AND PERSONAL INFORMATION

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

Name of Patient: _____

Date of Birth: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: **Mendocino County Behavioral Health and Recovery Services (Mental Health), 1120 S. Dora St. Ukiah, CA** to release to *(initial)*:

___ Primary Care Provider: Mendocino Community Health Clinic, 333 Laws Avenue, Ukiah, CA 95482

___ Primary Care Provider: Ukiah Rural Valley Health Clinic, 260 Hospital Drive, Ukiah, CA 95482

___ Mendocino County Alcohol, Drugs and Other Program (AOD): 1120 S. Dora St., Ukiah 95482

___ Mendocino County Public Health: 1120 S. Dora St., Ukiah 95482

___ Ortner Management Group: 1525 Plumas Court Ste. C, Yuba City, CA 95991

___ Integrated Care Management Services/Access Center: 1050 N State St. Ukiah, CA 95482

___ Manzanita Services, Inc: 270 North Pine St. Ukiah 95482 or 286 North School St. Willits 95490

___ Partnership Health Plan: 4665 Business Center Drive, Fairfield, CA 94534

___ Mendocino Coast Hospitality Center: 474 S. Franklin St. Ft. Bragg 95437

___ Hospital: _____
(Name & address – street, city, state, zip code)

___ Psychiatrist: _____
(Name & address of agency authorized to receive records)

___ Law Enforcement: _____
(Name & address of agency authorized to receive records)

___ Mendocino County Sheriff's Office: 951 Low Gap Road, Ukiah, CA 95482

___ Family Member / Support Person _____
(Name & relationship)

(Address – street, city, state, zip code)

(Other organization(s) or person(s) authorized to receive information, including address – street, city, state, zip code)

___ I authorize exchange of information between the above parties.

The following information (*initial*):

a. ___ All health information pertaining to my medical history, mental or physical condition and treatment received during time period
(*optional*) _____; OR

___ Only the following records or types of health information (including any dates): _____

b. I specifically authorize release of the following information (this information will not be released unless specifically authorized) (*initial*):

___ Mental health treatment information

_____ HIV test results (Health & Safety Code § 120980(g))

_____ Alcohol/drug treatment information (42 C.F.R. §§ 2.34 & 2.25)

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

PURPOSE

Purpose of requested use or disclosure: Patient request; OR Other:

EXPIRATION

This authorization expires on one year from the date of signature or on the following date: _____

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 inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: Mendocino County Behavioral Health and Recovery Services, 1120 D. Dora Street, Ukiah, CA 95482, Attn: Medical Records.

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

I have a right to receive a copy of this authorization.

Information disclosure pursuant to this authorization could be redisclosed by the recipient. Such disclosure is in some cases not prohibited by California law and may 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.

SIGNATURE

Date: _____ Time: _____ AM/PM

Signature: _____
(patient/legal representative)

If signed by other than patient, indicate

Relationship: _____

Print Name: _____

