CONROI

Comple on of this document authorizes the disclosure and/or use of health informa on about you. Failure to provide all informa on requested may invalidate this Authoriza on.

USE AND DISCLOSURE OF HEALTH INFORMATION

I HEREBY AUTHORIZE (select all that apply):

☐ Community Hospital of the Monterey Peninsula ☐ MoGo Urgent Care

☐ Montage Medical Group ☐ Community Health Innova ons

TO DISCLOSE TO:

_____

(Persons/organizations authorized to receive the information)

_____

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

THE FOLLOWING INFORMATION:

A. ☐ All health informa on pertaining to my medical history, mental or physical condi on and treatment received; **OR**

☐ Only the following records or types of health informa on (including any dates):

_____

B. I specifically authorize release of the following informa on (check and ini al next to box):

☐ _____Mental health treatment informa on
(*Initials)*

☐ _____HIV test results
(*Initials)*

☐ _____Alcohol/drug treatment informa on
(*Initials)*

A separate authoriza on is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regula ons implemen ng the Health Insurance Portability and Accountability Act.

PURPOSE

Purpose of requested use or disclosure:

☐ Patient request; **OR** ☐ Other: _____

Limita ons, if any: _____

MONTAGE Health

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION