CONROI

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

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 Innovations

TO DISCLOSE TO:

_____

(Persons/organizations authorized to receive the information)

_____

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

THE FOLLOWING INFORMATION:

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

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

_____

B. I specifically authorize release of the following information (check and initial next to box):

☐ _____Mental health treatment information
(*Initials)*

☐ _____HIV test results
(*Initials)*

☐ _____Alcohol/drug treatment information
(*Initials)*

PURPOSE

Purpose of requested use or disclosure:

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

Limitations, if any: _____

MONTAGE Health™

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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 address below (exceptions apply). 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 disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-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

Patient Name: _____ Date of Birth:_____

Date: _____ Time:_____ am/pm

Signature: _____ Telephone #:_____

If signed by someone other than the patient, print name and state your legal relationship to the patient: _____

Witness: _____

This authorization expires on: _____

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