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)

A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.

**PURPOSE**

Purpose of requested use or disclosure:

- [ ] Patient request; **OR** [ ] Other: ____________________________________________________________

Limitations, if any: ____________________________________________________________
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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