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MARIN CITY
Health & Wellness Center

Authorization for Release of Health Information
For Behavioral Health Records

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, set forth below, consistent with California and federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this Authorization.

Please fill out the following form to allow us to speak with anyone who may be important to your care. This could include your psychiatrist, a program or facility where you received treatment, your doctor outside of Marin City Health and Wellness Center, or someone else. We will usually talk to you before reaching out to the contacts you provide, but in certain situations we may be unable to do so in order to provide you with the most efficient and effective care. If you are unsure how to fill this out at this time you will have opportunities to fill this out at future visits or can complete a release in person at the clinic.

By signing this form, I *(print your name)* _____ authorize the release of the following personal health information for the purpose of continuity-transfer of care:

- All health information pertaining to any medical history, mental health, or physical condition and treatment received. This includes, but is not limited to:
  - Drug and alcohol abuse, diagnosis and/or treatment- (42 C.F.R. 2.34 and 2.35)
  - Mental Health diagnosis and/or treatment (Welfare and Institutions Code 5328, et seq.)
- (*Optional*) With the following limitations to disclosure: _____

This information is to be shared **between** the Marin City Health and Wellness Center, 630 Drake Ave; Sausalito CA 95965; PHONE: (415)339-8813, FAX: (415)339-8814, and the following person(s) or agencies/facilities:

Facility Name/Doctor: _____

Phone/Fax: _____

Address: _____

This authorization shall remain valid for 1 year since signature or until: _____

I understand that I have the right to:

- Refuse to sign this Authorization.
- I may modify, cancel, or revoke this authorization at any time. This must be in writing, signed by me or on my behalf, and delivered to the following address:
  630 Drake Avenue Marin City, CA 94965
- My revocation will be effective upon receipt but will not be effective retroactively given that the request to release may have occurred in reliance upon this Authorization.
- I have a right to receive a copy of this Authorization.
- Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this Authorization.

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- Information disclosed pursuant to this Authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPPA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is specifically required or permitted by law.
- I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

Patient signature: _____ Date: _____