Community Memorial Health System

Authorization for Use or Disclosure of Health Information Psychotherapy Notes

Patient's Name: _____ Birth Date: _____ MR#: _____ Bill #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone(s): _____ **E-Mail:** _____

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as 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.

NOTICE OF RIGHTS AND OTHER INFORMATION

1. I understand that this authorization is voluntary.
2. I may refuse to sign this authorization.
3. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this authorization. I understand the Notice of Privacy Practices provides instruction should I choose to revoke my authorization.
4. Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.
5. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might 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.
6. I may inspect or obtain a copy of the health information that I am being asked to use or disclose.
7. If this box ☐ is checked, the requestor will receive compensation for the use or disclosure of my information.
8. I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to: **Community Memorial Hospital, Health Information Department, 147 N. Brent Street, Ventura, CA 93003**
9. I understand that I have the right to choose how I am to receive my health information.
   a. Please choose a mode of delivery (choose one option):
      ☐ 1. Mail (address listed below)
      ☐ 2. Secure email to: _____
      ☐ 3. Fax request to: _____
      ☐ 4. In-person (by appointment only)
   b. Please choose a format (choose one option):
      ☐ 1. Paper
      ☐ 2. CD or flash drive (circle one)
      ☐ 3. Electronic file in "pdf" format

Please save and open file with Adobe Acrobat. May not open on a smart phone without Adobe Acrobat installed. Please check spam and junk mail folders when looking for email from CMHS.

• Please be advised that with utilizing fax or secure e-mail, there is some level of risk that your requested-health information could be read or otherwise accessed by a third party while in transit.

I understand I have the right to receive a copy of this authorization. (Civ. Code § 56.12)

I hereby authorize: ☐ Community Memorial Hospital ☐ Ojai Valley Community Hospital
☐ Centers for Family Health/Clinics (specify location): _____
☐ Other entity (specify location, example: VCMC or St. Johns Medical Center): _____

Release to: _____
(PERSONS / ORGANIZATIONS AUTHORIZED TO RECEIVE THE INFORMATION)

Address: _____ City: _____ State: _____ Zip Code: _____

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PLEASE SEE BACK FOR MORE INFORMATION.

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This authorization applies to the following information:

☐ Psychotherapy Notes (include specific information regarding Psychotherapy Notes that you want released i.e. date, therapist, etc. below)

Date(s): _____

Therapist(s): _____

Please note: California state law requires CMHS to obtain written permission from the attending physician.

Attending physician name (print): _____

For Office Use Only

Attending physician approval: ☐ **Yes** ☐ **No**

Signature: _____ **Date:** _____ **Time:** _____ **A.M. / P.M.**

PURPOSE

Description of each purpose of request use or disclosure: _____

EXPIRATION

This is a onetime use Psychotherapy Note authorization and is not to be utilized for any dates of service past the date of the authorization.

SIGNATURE

Patient/Representative/Spouse/Financially Responsible Party: _____

Date: _____ Time: _____ A.M. / P.M.

If signed by someone other than the patient, state your legal relationship: _____
If patient's legal representative, please provide supporting documentaion such as power of Attorney, Death Certificate if patient is expired, Conservatorship or Proof of Custody.

☐ ID checked

I hereby authorize _____ to pick up my records.

☐ ID checked

Hospital representative processing request: _____

Date: _____

SUBMIT

Community Memorial Hospital • Medical Records/Health Information Department • 147 N. Brent Street, Ventura, CA 93003
Phone 805-948-5047 • Email ROIrequests@cmhshealth.org • Fax 805-652-5649

Ojai Valley Community Hospital • Medical Records/Health Information Department • 1306 Maricopa Hwy., Ojai, CA 93023
Phone 805-640-2215 • Fax 805-640-1649

Centers for Family Health • Medical Records/Health Information Department
Please use Community Memorial Hospital contact information above
Phone 805-948-5047 • Fax 805-652-5649

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