



## Authorization for Release of Information (ROI)

This form lets you or someone you trust give Marin Community Clinics permission to get or share your health information. Your health records are private. They are protected by laws like HIPAA, California's privacy law, and special rules for drug and alcohol treatment.

### Patient Information (please print clearly):

Patient Name:	Date of Birth:	Phone: E-mail:
Patient Address, City, State & Zip		

### Section 1 – Release TO or FROM

I authorize **Marin Community Clinics (MCC)** to get or share the medical information indicated on this form.

- To** self (Adults only)
- Get **FROM** the third party below                       Share **TO** the third party below

Full Name/Organization: \_\_\_\_\_

Affiliation/Role (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_

- More than one agency. (Also complete page 3)

### Section 2 – Delivery Option

I request that MCC release my records in the following format (**check all that apply**):

- Phone Call (to healthcare provider, school, legal)                       Mail
- Fax (to healthcare provider only)     Pick-up
- Other: \_\_\_\_\_

### Section 3 – Information to be Released

Please specify date range (if applicable): from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

- |   |   |
|---|---|
| <input type="checkbox"/> Complete Medical Record  | <input type="checkbox"/> Radiology Reports                |
| <input type="checkbox"/> Dental Records           | <input type="checkbox"/> Radiology Imaging Only           |
| <input type="checkbox"/> Dental/Medical Clearance | <input type="checkbox"/> Treatment Verification Letter    |
| <input type="checkbox"/> Immunization Records     | <input type="checkbox"/> Visit Summaries / Progress Notes |
| <input type="checkbox"/> Lab Results              | <input type="checkbox"/> Verbal Communication             |
| <input type="checkbox"/> Dental Radiology Imaging | <input type="checkbox"/> Other (please specify): _____    |

**Sensitive records:** Under Federal and California law (42 CFR Part 2, Cal. HSC §11845.5, etc.) these categories have additional protections. Initial for each category:

- |  |                 |
|--|-----------------|
| <input type="checkbox"/> Behavioral Health Records*                | Initials: _____ |
| <input type="checkbox"/> Substance Use Disorder Treatment Records* | Initials: _____ |
| <input type="checkbox"/> HIV/AIDS Test Results*                    | Initials: _____ |

\*These sensitive records will not be released unless specifically authorized by initialing next to each category.

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**Section 4 – Purpose of Disclosure**

The requested records are being released for the following reason(s) (check all that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> Continuity of Care / Treatment     | <input type="checkbox"/> Education / School Entry (e.g., immunization records) |
| <input type="checkbox"/> Personal Copy                      | <input type="checkbox"/> Employment  |
| <input type="checkbox"/> Legal Purposes                     | <input type="checkbox"/> Doctor's Note (specify): _____                        |
| <input type="checkbox"/> Insurance / Payment                | <input type="checkbox"/> Other (please specify): _____                         |
| <input type="checkbox"/> Disability / Workers' Compensation |  |

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**Section 5 – Patient Rights & Acknowledgments**

- I'm signing this form because I want to.
- If I ask for my information by email or text, I know it may not be fully secure.
- I understand that I am entitled to receive a copy of this authorization form.
- I can change my mind later by sending a letter, but this won't undo anything that's already been shared.
- To cancel this form, I need to write to MCC's Health Information Department.
- This form will expire in one year, unless I write a different date.
- MCC will not treat me unfairly, charge me more, or take away my care if I don't sign this form.
- The person who gets my health information cannot share it with anyone else unless I say it's okay in writing, or if the law says they can.
- The clinic, staff, and doctors can share my information if the law says it's okay, and they won't get in trouble for it.

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**Expiration Date (if earlier than 1 year):** \_\_\_\_\_

**This form was explained to me in a language I understand.**

**Patient/Legal Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If signed by Legal Representative, state authority (e.g., parent, legal guardian, POA):**

**Legal Representative Name:** \_\_\_\_\_ **Phone:** (\_\_\_\_) \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

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**Clinic Use Only:**

- Received by: \_\_\_\_\_ Date: \_\_\_\_\_

**For HIMS Use Only:**

- Verified ID:  Yes  No
- Processed by: \_\_\_\_\_ Date: \_\_\_\_\_
- Records released via:  Mail  Fax  Phone  Email  Pick-up

*See following page to release to more than one agency (if applicable)*



Authorization for Release of Information (ROI)

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Multi-Agency Release

I give Marin Community Clinics and the checked agencies below permission to talk, share, or exchange written or verbal information about the patient’s medical care, education, or mental health. This may include things like test results, education plans (IEPs), or family service plans (IFSPs).

Table with 3 columns: Agency Name, Initials, Date. Lists various agencies like Children and Family Services (CFS), Marin Family Connections, Golden Gate Regional Center, etc.

Everything in Section 5 still applies here — including your right to cancel this form, how long it lasts, and how your info can or can't be shared.