Marin Community Clinics

PERMISSION TO DISCUSS CARE AND COORDINATE SERVICES

(Adult Patients Age 18 and Older)

Marin Community Clinics (MCC) may discuss my healthcare, appointments, treatment, medications, billing, and care coordination with the person(s) listed below.

This permission helps MCC communicate with family members, friends, caregivers, or other individuals involved in my care.

PLACE STICKER HERE

Patient Name:

_____

Date of Birth:

☐ I DO NOT authorize Marin Community Clinics (MCC) to share my health information.

******If this box is checked, do not complete the sections below. ******

I understand:

- This permission is voluntary and I may revoke this permission at any time by notifying MCC in writing. Revocation applies only to the individual identified on this form.
- Revocation will not apply to information already shared before MCC receives my request.
- This form does not authorize release of copies of my medical records. Requests for medical records require a separate authorization process.
- MCC will disclose information consistent with this permission and applicable law.

AUTHORIZED INDIVIDUAL

MCC may request identification or verification before discussing information with an authorized individual.

Name: _____

Relationship to Patient: _____

Phone Number: _____

This person may *(select each item)*:

☐ Discuss my healthcare and treatment with MCC staff (Includes medications and care instructions)

☐ Schedule, change, or cancel appointments

☐ Discuss billing, insurance, and payment matters

☐ Pick up forms and paperwork on my behalf

Expiration *(select one)*:

☐ This permission expires one (1) year from the date signed.

☐ Other expiration date: _____ / _____ / _____

Patient Signature: _____ Date: _____

** This form does not authorize release of medical records, psychotherapy notes, substance use disorder treatment records, or other information protected by federal or state law that requires separate authorization.*