MARIN CITY
Health and Wellness Center

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
For Behavioral Health Records

Completion of this form authorizes the disclosure and/or use of individually identifiable health information as specified below, in accordance with California and federal privacy laws. Failure to complete all required sections may result in an invalid authorization.

Purpose of This Authorization

This form allows Marin City Health and Wellness Center (MCHWC) to communicate with individuals or entities involved in your care, including psychiatrists, treatment programs/facilities, primary care providers outside of MCHWC, or other relevant parties. We will typically discuss this with you before reaching out to the contacts you provide; however, in some cases, we may need to proceed without prior discussion to ensure timely and effective care.

If you are unsure how to complete this form, you may do so on a future visit or in person at the clinic.

Patient Information

I, (Print Name): _____
Date of Birth (DOB): ___ / ___ / _____

authorize the release of the following personal health information for the purpose of continuity or transfer of care:

☐ All health information related to my medical history, mental health, or physical condition, including treatment received. This may include:

- Substance use disorder (SUD) treatment records (42 C.F.R. Part 2)
- Mental health diagnosis and/or treatment (Welfare & Institutions Code § 5328 et seq.)

☐ Limitations on disclosure (Optional): _____

MARIN CITY
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Authorized Release To/From

I authorize Marin City Health and Wellness Center to release/exchange this information with:

Name of facility, provider, or other entity:

_____

Phone/Fax:

_____

Address:

_____

Authorization Expiration

This Authorization remains valid for one (1) year from the date of signature unless a specific expiration date is indicated:

Expiration Date: ___ / ___ / _____

Patient Rights & Acknowledgments

I understand that:

- I have the right to refuse to sign this Authorization.
- I may modify, cancel, or revoke this Authorization at any time in writing.
    - A written revocation must be signed and delivered to:
      Marin City Health and Wellness Center, 100 Phillips Drive, Sausalito, CA 94965.
    - The revocation will take effect upon receipt but will not apply retroactively to any disclosures already made.
- I have the right to receive a copy of this Authorization.
- This Authorization does not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign.
- Disclosed information may be subject to re-disclosure by the recipient and might no longer be protected by federal privacy laws (HIPAA).
    - However, California law restricts further disclosure unless permitted or required by law.
- I may inspect or obtain a copy of the health information covered by this Authorization.

Patient Signature

Patient signature: _____ Date: _____