Appendix 14 ▪ Authorization for Use and Disclosure of Protected Health Information

Name of Client: _____ MSSP #: _____

I hereby authorize the use and disclosure of protected health information about the above client for the purposes of use by MSSP as follows:

A. I authorize MSSP Site Name: _____ to make requested

release or disclosure to: _____.

B. I authorize MSSP Site Name: _____ to receive and use my

protected health information from: _____.

C. Description of client's protected health information to be used or disclosed:

Check All that Apply:

- ☐ Physical Injuries, illnesses or conditions
- ☐ Mental (psychological or psychiatric) illnesses or conditions
- ☐ Alcohol Abuse and/or drug abuse
- ☐ Cash Assistance, Medi-Cal benefits or other social and health services received
- ☐ Other (If checked, must describe): _____

D. Client's protected health information is being used or disclosed for the following purpose(s) by MSSP:

To determine the client's eligibility for MSSP, for their care management, for their health/psychosocial assessments, and for administrative purposes by staff.

I understand that I have the following rights with respect to this Authorization:

1. MSSP Site Name:_____ as the recipient of the protected health information may not further disclose the information unless MSSP Site Name:_____ obtains another authorization from me or unless the disclosure is permitted by law.

2. I may not be required to sign this Authorization as a condition to obtain treatment (i.e., services) or payment or my eligibility for benefits.

3. MSSP Site Name: _____ will provide me with a copy of this Authorization.

4. I may revoke this Authorization at any time by mailing or personally delivering a signed, written notice of revocation to MSSP Site Name: _____. Such revocation will be effective upon receipt, except to the extent that MSSP Site Name: _____ has already taken action in reliance on this Authorization. Such revocation will remain in effect until I authorize, in writing, the release of the protected health information, except where the release of the protected health information is required or permitted by law.

5. I understand that this authorization will automatically expire two (2) years from the date of this authorization regardless of any other revocation I may request.

6. MSSP Site Name: _____ will not use or disclose the protected health information for marketing or receive compensation for the use or disclosure of my protected health information.

This Authorization will expire on date: _____ OR 2 (two) years from the date of signature.

Client's Signature/Representative: _____ Date: _____

Relationship of Representative to Client (if applicable): _____

Printed Name: _____ Date: _____

Address: _____ Telephone: _____