Mountain Counties Case Management Programs

Serving Lassen, Modoc, Plumas, Sierra & Siskiyou Counties

CONSENT FOR EXCHANGE OF CONFIDENTIAL INFORMATION

Client's Name: _____
Last **First** **MI**

Address: _____
Street **City** **State** **Zip**

Telephone: _____ **DOB:** _____/_____/_____

I hereby authorize Mountain Counties Case Management & EIS Programs to exchange with the providers/agencies selected and initialed below all records and information pertaining to medical history and lab evaluation, mental or physical condition, services rendered, or treatment thereof. I understand that this exchange of information is necessary to provide comprehensive patient care, coordinate referrals, assessment, services and case management for me. I understand that the providers/agencies selected below will preserve confidentiality of all client information and that this consent authorization is valid only for the time period specified below. All or any part of this consent is canceled upon receipt of written notification from the undersigned. Absolutely no information about me or my family will be released to any third party, except my insurance provider, without my written consent, or that of my representative appointed in accordance with state law. I understand that I have the right to receive a copy of this authorization.

Date: _____ Client's Initials	Date _____ Client's Initials	Date _____ Client's Initials	Provider/Agency to which information is being released
_____	_____	_____	Mountain Counties Case Conference Staff (medical provider, patient coordinator, health educator, social worker, dietician, & nurse case manager)
_____	_____	_____	Private Medical Provider(s): _____ _____ _____
_____	_____	_____	Social Security Office (SSI, SSDI)
_____	_____	_____	Human Services (MediCal, Food Stamps)
_____	_____	_____	Pharmacies:
_____	_____	_____	Home Care Agency
_____	_____	_____	Family Members:
_____	_____	_____	Social Services (In Home Support)
_____	_____	_____	Employment Development (State Disability)
_____	_____	_____	CQI Committee, State & Federal OA Contract Monitor *(for chart review and quality assurance only)*
_____	_____	_____	Health Department
_____	_____	_____	Other:

This authorization is ☐not limited ☐limited to the following specific type of information: _____

_____

This release will expire on: _____

Executed this _____day of _____ 20_____.

Signature of Client: _____

Signature of Witness (optional):_____

Update: Signature: _____ Date: _____

Witness Signature (Optional): _____ Date: _____

Update: Signature: _____ Date: _____

Witness Signature (Optional): _____ Date: _____