MODOC MEDICAL CENTER
A Public Entity
Healing Hands Close To Home
Last Frontier Healthcare District

FAMILY PRACTICE CLINIC

P: 530-708-8820
F: 530-233-4302

Please bring the following to your first appointment:

1.) Insurance Cards and Valid ID
2.) All Attached Documents-Completed
3.) Recent Medical Records
4.) Prescription Bottles
5.) Co-Payment

Please arrive 15 minutes before your appointment time.

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Patient Packet Completion Instructions

Thank you for taking the time to complete the enclosed **Patient Packet**. The information you provide will help us deliver the best possible care. Please follow the steps below to ensure all necessary details are included:

1. **Review and complete** each section of the Patient Packet thoroughly.
2. **Sign and date** all areas that are highlighted. This is crucial to avoid any delays in processing your paperwork.
3. **Medical Records Requirement:**
    - If you are currently taking any medication, we will need to obtain your medical records from the provider who prescribed that medication.
    - Our clinic will request your medical records directly from your **previous healthcare provider** once we receive your completed Patient Packet.
4. Once both your completed Patient Packet and medical records have been received, **our Scheduling Department will contact you** to set up your first appointment.

If you have any questions or need assistance with any part of the packet, please feel free to reach us at 530.708.8820.

Thank you for your cooperation. We look forward to providing you with exceptional care.

Modoc Medical Center Clinic
1111 N Nagle Street, Alturas CA 96101
P: (530) 708-8820 F: (530) 233-4302

PATIENT REGISTRATION

Patient Information: (Please print clearly) Name must match what is on your insurance card or ID.

Last Name: _____ **First:** _____ **M:** _____

Sex/Gender Identity: ❑F ❑M ❑Male identifying as female ❑Female identifying as male ❑Other _____

Birthdate: _____ **SSN#** _____ **Marital Status:** ❑S ❑M ❑D ❑W ❑SEP

Mailing Address: _____ **City:** _____ **ST:** _____ **Zip:** _____

Physical Address (if different): _____ **City:** _____ **ST:** _____ **Zip:** _____

Primary Phone: _____ **Work:** _____ **Cell:** _____

Message #: _____ **Email Address:** _____

Occupation: _____ **Retired?** ❑Yes ❑No **Date:** _____

Preferred Method of Contact: ❑Home Phone ❑Work ❑Cell ❑Message Phone ❑Text ❑Email **Okay to Text:** ❑Yes ❑No

Emergency Contact: _____ **Phone:** _____

Relationship: _____ **Does this person know that you are a patient at MMC Clinic?** ❑Yes ❑No

Parent or Guardian (if patient is minor) or Spouse Information:

Parent or Spouse Name: _____ **SSN#** _____

Address (if different than patient): _____ **City:** _____ **ST:** _____ **Zip:** _____

Phone (if different than patient): **Home:** _____ **Work:** _____

Cell: _____ **Birthdate:** _____ **Sex:** ❑F ❑M **Marital Status:** ❑S ❑M ❑D ❑W ❑SEP

Insurance Information:

Primary Insurance: _____

Subscriber Name: _____ **DOB:** _____ **Sex:** _____

Relationship to Patient: _____ **Subscriber ID:** _____ **Group:** _____

Secondary Insurance: _____

Subscriber Name: _____ **DOB:** _____ **Sex:** _____

Relationship to Patient: _____ **Subscriber ID:** _____ **Group:** _____

Financially Responsible Party: ❑Patent info above ❑Parent/Guardian/Spouse info above

Last Name: _____ **First Name** _____

Address: _____ **City:** _____ **ST:** _____ **Zip:** _____

Relationship to Patient: _____ **Phone:** _____

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1111 N Nagle Street, Alturas CA 96101
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Patient Last Name: _____ **First Name:** _____

Patient Demographics: To enable us to qualify for our grants and meet our Federal and State reporting requirements, along with possibly allowing us to offer more services, we ask for the following information. Your answers are strictly confidential. Your name will not be used. Please Circle or Check the appropriate box.

Language Spoken in your Home: ❑English ❑Spanish ❑Other: _____

Race (Check all that apply): ❑White ❑Black/African American ❑Native Hawaiian/Pacific Islander ❑Asian ❑Chinese ❑American Indian/Alaskan Native ❑Filipino ❑Japanese ❑Korean ❑Other ❑Declined

Ethnicity: ❑Hispanic/Latino ❑Non-Hispanic/Latino ❑Declined

Are you a Veteran?: ❑Yes ❑No **Agricultural (Farm) Worker?:** ❑Yes ❑No **If yes, are you:** ❑Seasonal ❑Migrant

Homeless?: ❑Yes ❑No **If yes, currently living in:** ❑Shelter ❑Transitional Housing ❑Doubled Up ❑Street ❑Other

Sexual Orientation (over 18 years old): ❑Heterosexual (Straight) ❑Gay or Lesbian ❑Bisexual ❑Choose not to disclose

Does the patient require a caregiver? ❑Yes ❑No If yes, Name of Caregiver: _____

Would you like information from your provider on Advanced Healthcare Directives? ❑Yes ❑No

Other health specialists Involved in patient's care:

Name	***City***	***Phone***
Name	***City***	***Phone***

Pharmacy Information:

What pharmacy do you use? _____ **Location:** _____

Sign and Authorize: The information I gave on this form is true and correct to the best of my knowledge.

_____ _____

Patient or Responsible Party Signature ***Date***

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PAST MEDICAL HISTORY

M/R#_____ DATE: _____ DOB: _____ NAME: _____

Please CIRCLE all the conditions you have/had at ANY TIME. If unsure, underline the condition.

Heart Conditions:
- Heart Attack
- Heart Failure
- Angina/Heart Pain
- Other Heart Disease
- Rheumatic Fever
- Stroke

Neurological:
- Epilepsy/Seizures
- Migraine Headaches
- Concussion
- Memory Issues
- Numbness in Arms/Legs
- Other Neurological Disorders

Respiratory:
- Asthma
- Bronchitis
- Pneumonia
- Tuberculosis
- Pleurisy
- Other Respiratory Conditions

Skin & Allergy:
- Eczema
- Hives/Hay Fever
- Skin Rash
- Other Skin Conditions

Kidney/Urinary:
- Bladder Infection
- Kidney Infection
- Kidney Stones
- Blood in Urine
- Slow Starting Urine

Endocrine
- Goiter/Thyroid Disease
- Diabetes
- Hormonal Imbalance
- Other Endocrine Conditions

Gastrointestinal:
- Stomach Ulcers
- Colitis
- Bloody Stools/Vomit
- Diarrhea
- Constipation
- Gallstones

Other:
Psychiatric Issues (e.g., Depression, Anxiety)
Arthritis/Bursitis
Chronic Back Problems
Cancer: _____

Blood & Circulatory:
- Anemia
- Bleeding Disorders
- Blood Clots (Legs/Lungs)
- High Blood Pressure
- High Cholesterol

SURGICAL HISTORY
Please list all OPERATIONS (Surgeries) & approximate dates:
_____

HOSPITALIZATIONS & ILLNESSES
List all HOSPITALIZATIONS or ILLNESSES not covered above:
_____

MEDICATIONS
Current Medications:
(Please include all prescriptions, over-the-counter medications, laxatives, sleeping pills, sedatives, etc.)
_____
Medication Allergies:
_____
Food Allergies:
_____

FAMILY HISTORY

If any immediate family members have been ill, CIRCLE their illness and indicate the relationship.

Heart Conditions:
- Heart Attack
- Heart Failure
- Angina/Heart Pain
- Other Heart Disease
- Rheumatic Fever
- Stroke

Neurological:
- Epilepsy/Seizures
- Migraine Headaches
- Concussion
- Memory Issues
- Numbness in Arms/Legs
- Other Neurological Disorders

Respiratory:
- Asthma
- Bronchitis
- Pneumonia
- Tuberculosis
- Pleurisy
- Other Respiratory Conditions

Skin & Allergy:
- Eczema
- Hives/Hay Fever
- Skin Rash
- Other Skin Conditions

Kidney/Urinary:
- Bladder Infection
- Kidney Infection
- Kidney Stones
- Blood in Urine
- Slow Starting Urine

Endocrine
- Goiter/Thyroid Disease
- Diabetes
- Hormonal Imbalance
- Other Endocrine Conditions

Gastrointestinal:
- Stomach Ulcers
- Colitis
- Bloody Stools/Vomit
- Diarrhea
- Constipation
- Gallstones

Other:
Psychiatric Issues
Arthritis/Bursitis
Chronic Back Problems
Cancer: _____

Blood & Circulatory:
- Anemia
- Bleeding Disorders
- Blood Clots (Legs/Lungs)
- High Blood Pressure
- High Cholesterol

Father's Age: _____
- Health: [ ] Good [ ] Fair [ ] Poor
- Cause of Death (if applicable): _____

Mother's Age: _____
- Health: [ ] Good [ ] Fair [ ] Poor
- Cause of Death (if applicable): _____

WOMEN'S HEALTH HISTORY

Age of First Period: _____ Date of Last Period (LMP): _____

Regularity of Periods:
- Regular
- Irregular

Menstrual Flow:
- Light
- Normal
- Heavy/Very Heavy

Menstrual Pain (Cramps):
- None
- Mild
- Moderate
- Severe

Number of Pregnancies: _____
Number of Live Births: _____
Number of Miscarriages: _____
Number of Stillbirths: _____
Number of Abortions: _____
Number of C-Section Births: _____

Contraceptive Use:
Birth Control Pills
IUD
Condom
Depo-Provera
Implants
Sterilization/Vasectomy
Other: _____

Gynecological Conditions:
- Fibroids
- Ovarian Cysts
- Endometriosis
- Pelvic Inflammatory Disease (PID)
- Polycystic Ovary Syndrome (PCOS)
- Abnormal Pap Smear
- Menopausal Symptoms (e.g., hot flashes, night sweats)
- Hormonal Imbalance
- Urinary Incontinence
- Vaginal Infections
- Other (Please specify):

_____

- **Breast Health:**
- Regular self-exams
- Previous Mammogram
- History of Breast Lumps
- Nipple Discharge
- Other Concerns:

_____

Gynecological Surgeries (other than C-Section):
- Yes [ ] No
- If yes, please specify:

_____

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M/R#_____

AUTHORIZATION FOR TREATMENT

AUTHORIZATION FOR TREATMENT: The patient is under the care of their attending physician or the emergency room physician on duty and Modoc Medical Center (MMC) is not liable for any acts of omission in following the instructions of said physicians. The patient consents to an X-Ray examination, laboratory procedures, anesthesia, medical or surgical treatment or hospital services rendered to the patient under the general and special instructions of the physicians. The patient recognizes that all medical doctors furnishing services, including emergency room doctors, radiologist, pathologists, and the like are independent contractors and are not employees or agents of MMC.

RELEASE OF INFORMATION: MMC may disclose all or any part of the patient's record to any person or corporation that is, is or may be liable under a contract or otherwise responsible to MMC, to the patient, or to a family member or employer of the patient, for all or part of MMC's charges. This includes, but is not limited to, MMC or medical services companies, insurance companies, worker compensation carriers, welfare funds or the patient's employer.

MEDICARE ASSIGNMENT OF BENEFITS: If applicable, the patient certifies that the information given by me in applying for payment under Title XVII (Medicare) of the Social Security Act is correct. The patient authorizes any holder of medical or other information to release to the Social Security Administration, its intermediaries, or carriers any information needed for this or a related Medicare claim. The patient requests that payment of authorized benefits be made on my behalf to MMC.

FINANCIAL AGREEMENT: The patient agrees, whether they sign as an agent or a patient, that in consideration of the services rendered to the patient, they hereby individually obligate themselves to pay the account at MMC. The patient understands that if the charges are covered by insurance of any type, it is nevertheless my personal obligation to pay for all charges billed that are not covered by their insurance. A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

HOSPITAL-WIDE CONSENT FOR HIV BLOOD TESTING: If health care personnel involved in the patient's care and treatment become exposed to certain bodily fluids, resulting in the possibility of transmission of blood borne disease, the patient's blood will be tested in order to detect whether or not the patient has antibodies to the Human Immunodeficiency Virus (HIV). This is the probable causative agent of Acquired Immune Deficiency (AIDS). The patient understands that this test is performed by with drawing blood and using a substance to test the blood. The patient also understands that there will be no charge for the performance of this test if occupational exposure occurs. If, during the course of treatment, the physician orders this test for diagnostic purposes, the patient will be charged accordingly.

The test and its accuracy and reliability are still uncertain, and the test results may, in some cases, indicate that a patient has antibodies to the virus when the patient does not (false Positive) or fail to detect that a patient has antibodies to the virus when the patient has antibodies (false Negative). A positive blood test result does not mean that the patient has AIDS and that in order to diagnose AIDS other means must be used in conjunction with the blood test. The patient may ask the responsible physician any questions regarding the nature of the blood test, its risks, and alternative testing before the test takes place.

The patient understands that the result of this blooc test will only be made available to the Medical Records director and Infection Control Officer for employee follow up and to the patient's treating physician and will be kept strictly confidential.

By signing, I acknowledge that I have read the above "Authorization for Treatment." I also give consent for the performance of a blood test to detect antibodies to the HIV, without a physician's order as discussed above. I further understand that during my treatment, my physician may order an HIV test for diagnostic purposes, regardless of this consent.

PATIENT SIGNATURE _____

AUTHORIZED AGENT _____ **RELATIONSHIP**_____

WITNESS _____ **DATE**_____

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M/R#_____

OFFICE PROCEDURES

1. Name: It is procedure to address you by first or last name. How would you like to be addressed?
   _____

2. Phone Confirmations: It is procedure to have you call 24-hours before your appointment to cancel.
   a. We may also call you regarding medical issues. List two phone numbers where you can be reached:
   Phone 1:_____
   Phone 2:_____
   b. If we cannot reach you at either number, may we call you at home? Yes / No
   c. If no one is home, may we leave a message on your answering machine? Yes / No

3. Verbal Authorization: It is procedure to get verbal authorization from all new patients to confirm appointments and leave messages if the patient is not available.

4. Sign-In Sheets: Insurance companies require that we have proof of your visit to our office for treatment on the date billed. In order to verify this, we have a daily sign-in sheet that you sign at the time of your appointment.

5. List those who we may share your medical information with: (Patient to initial all that apply)

Initial	Name	Phone Number
Initial	Name	Phone Number
Initial	Name	Phone Number

6. Our office is HIPAA-compliant and the staff has been trained in the HIPAA Privacy Act. We will do everything we can to protect your Patient Health Information and appreciate your help with this.

   PATIENT NAME_____

   SIGNATURE_____DATE_____

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M/R#_____

Appointment Cancellation, Missed Appointment, and Late Arrival

The vision of Modoc Medical Center's (MMC) Family Practice Clinics (Clinics) is to provide the highest quality healthcare in a way that reflects kindness and respect while allowing all people to feel valued as human beings. To ensure that each patient is given the proper amount of time for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time.

As a courtesy, an appointment reminder is attempted one (1) business day prior to your scheduled appointment. If you do not receive a reminder call/message or the number has been disconnected or changed this policy remains in effect. It is the patient's responsibility to keep contact information current with our office and to arrive for their appointments on the scheduled date and time.

We understand that appointments are missed due to emergency situations. Please call the Clinic promptly if you are unable to show up at your scheduled time. If you need to reschedule your appointment, we request that you give our office at least 24 hours' notice. If you do not provide us with at least 24-hours' notice, or if you do not show up for a scheduled appointment, this will be considered a Missed Appointment.

Our appointment Cancellation, Missed Appointment, and Late Arrival Policy states:

- **Three (3) no-shows in a six (6) month period or four (4) in a 12-month period may lead to you being dismissed from Alturas Family Practice Clinic and Canby Family Practice Clinic.**
- **First Missed Appointment:** Patient will be contacted by our staff and offered to reschedule the missed appointment.
- **Second Missed Appointment:** Patient will receive a phone call and be mailed a letter reinforcing the Missed Appointment Policy as well as indicating potential of dismissal from the Clinic should they fail to keep future appointments or provide appropriate notification.
- **Third Missed Appointment:** If within six months, the Clinic Provider and Clinic Director/Manager will review the Patients records to determine if dismissal from care is appropriate. If dismissal is appropriate, a Certified Letter will be mailed via USPS to the patient with instructions to seek medical care elsewhere, the Patient will also receive a second copy of the letter sent via regular mail. The patient will be given 30 days of medications, if needed, to allow time for care to be established.
- **Fourth Missed Appointment:** If within 12 months, Clinic Director/Manager and Medical Provider will review the Patient's record/chart to determine appropriateness of dismissal. If dismissal is deemed appropriate, a letter will be sent via Certified Mail/Return Receipt Required to the patient as well as a second copy of the letter sent via regular mail.
- **Late Arrival:** Any patient more than five (5) minutes late for any 15-minute or same-day appointment, or seven (7) minutes late for a 30-minute or longer appointment will be asked to reschedule. The front desk staff will notify the Medical Provider of the tardy patient and the Medical Provider will make the decision as to whether they can see the patient or not.

***If a patient is discharged from the Clinic(s) and has a medical emergency, please visit the Emergency Department at MMC.**

I have read and understand MMC's Family Practice Clinics Appointment Cancellation, Missed Appointment, and Late Arrival Policy and I understand that I will be held accountable by its terms. I also understand that such terms may be modified depending on the best interest of the patients, employees, and organization.

Patient Signature _____ **Date** _____

***If declining to sign, please understand that the terms contained in these policies are still in effect and will be enforced for all scheduled appointments.**

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AUGMEDIX Technology

Your providers are using a new technology called AUGMEDIX. AUGMEDIX is a technology that uses a remote assistant/scribe to assist your provider with documenting your visit today. This assistant/scribe will assist in creating your electronic medical record in real time.

I have read the frequently asked questions sheet given to me by the **Medical Clinic at Modoc Medical Center** and have had all my questions answered by the health center staff.

I have also been informed that it is my choice whether or not I want AUGMEDIX utilized during my visit with my provider.

By signing below, I am consenting to the use of AUGMEDIX technology. This consent is valid from the date I sign, for all future visits. At any point in time it is my right to decline the use of AUGMEDIX

Patient Name _____ Date of Birth _____

Patient Signature _____

Date _____

Front Office Staff _____

MODOC MEDICAL CENTER
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MR#_____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We Have a Legal Duty to Safeguard Your Protected Health Information (PHI)

We are legally required to protect your health information (PHI) and to follow the privacy practices described in this notice.

Care Coordination and Case Management

We may use and disclose your protected health information for purposes of care coordination and case management with other healthcare providers, health plans, and healthcare organizations involved in your care.

How We May Use and Disclose Your PHI

- For Treatment, Payment, and Health Care Operations as permitted by law.
- For public health activities, health oversight, research, organ donation, workers' compensation, and to avoid serious harm.
- For appointment reminders and information about treatment alternatives or services.

Additional Patient Protections and Rights

Confidential Communications

You may request communication by phone, voicemail, text message, email, or patient portal and we will accommodate reasonable requests.

Restriction When Paying Out-of-Pocket

If you pay out-of-pocket in full, you may request we not disclose that information to your health plan, and we must honor that request.

Breach Notification

You have the right to be notified if your unsecured PHI is breached.

Special Protection for Reproductive Health Information

We will not disclose PHI for investigation or liability related to lawful reproductive health care. We must obtain a signed attestation before releasing information that may involve reproductive care.

Substance Use Disorder Records (42 CFR Part 2)

Certain SUD treatment records have additional federal protections and may require specific authorization before disclosure.

Your Rights Regarding Your PHI

- Request limits on uses and disclosures
- Request confidential communications
- Access and receive copies of your PHI in paper or electronic form
- Request corrections to your PHI
- Receive an accounting of disclosures
- File a complaint without retaliation

No Waiver of Rights

We will not require you to waive any of your HIPAA privacy rights as a condition of treatment or payment.

Right to Electronic Copies

You have the right to receive your PHI in electronic form when readily producible.

How to Express a Concern About Our Privacy Practices

If you believe that your privacy rights may have been violated, or you disagree with a decision we made regarding access to your protected health information, you may file a complaint with our Privacy Officer.

Privacy Officer Contact Information:
Risk Management
PO Box 190
Alturas, CA 96101
Phone: (530) 708-8888

You may also file a complaint directly with the U.S. Department of Health and Human Services, Office for Civil Rights at:
50 United Nations Plaza, Room 322
San Francisco, CA 94103

Filing a complaint will not affect your care or result in any retaliation.

Person to Contact for Information About This Notice:
If you have questions about this Notice or concerns about patient safety or quality of care, you may contact the Risk Manager at the number listed above. You may also contact hospital administration or the California Department of Public Health (CDPH) at (800) 554-0350.

Other Uses of Medical Information

Other uses and disclosures of protected health information not covered by this Notice or the laws that apply will be made only with your written authorization. If you provide us permission to use or disclose your information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your information for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain records of the care that we provided to you.

Right to a Paper Copy of This Notice

You have the right to receive a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. You may obtain a copy of this Notice from the Admissions Department or Nursing Department.



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have been offered and/or received a copy of the Notice of Privacy Practices. This acknowledgment is not a consent for treatment.

Patient Name: _____

Patient Signature: _____ Date: _____

Representative (if applicable): _____ Relationship: _____

Signature: _____ Date: _____

If unable to sign, explanation: _____

Staff Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Revised 2/2026

*****REQUEST FOR RECORDS*****

We will need to obtain your primary care records prior to scheduling an establishing appointment. We would also like to have your specialty records to aid you in your care. The following three pages will need to be completed in full and signed appropriately. We will fax or mail the requests as appropriate.

INSTRUCTIONS:

1.) **Primary Care** *Authorization for Release of Protected Health Information*

2.) If applicable: **Specialist** *Authorization for Release of Protected Health Information*

Please feel free to make a copy of the Specialist page should you have more than one Specialist for which we will need to obtain your records.

MAKE SURE TO COMPLETE **IN FULL** THE FOLLOWING:

THE PATIENT INFORMATION SECTION

THE FACILITY NAME SECTION

DOCUMENTS TO BE DISCLOSED/RELEASED SECTION

3.) The last page with your signature, printed name, and date. If other than the Patient is signing, you must attach the legal document that gives permission to sign on behalf of the Patient.

Please Note: Failure to complete the Authorizations in full, may cause a delay in your care. Authorizations for Records are governed by HIPAA laws. If not completed in full and properly your previous care providers may reject the request for records.

PRIOR PRIMARY CARE

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I understand that information disclosed pursuant to this authorization could be redisclosed by the recipient and that such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal law (HIPAA).

Completion of this document authorizes the disclosure and/or use of health information about you. Please be sure to provide all information requested, failure to do so may invalidate this authorization.

PATIENT INFORMATION:

Patient Name:		Last 4 of SS#:
Address:	City:	State:
Zip Code:	Telephone:	Date of Birth:

I HEREBY REQUEST AND AUTHORIZE:

Name: **MODOC MEDICAL CLINIC**

Address: P.O. BOX 190, 1111 N NAGLE ST	City: ALTURAS	State: CA	Zip Code: 96101
Telephone: 530-708-8820	Fax: **530-233-4302**		

CHECK ONE BOX: ☐ To **release** to ☒ To **request** from

Name:			
Address:	City:	State:	Zip Code:
Telephone:	Fax:		

In the following manner:

- ☒ Copies by mail (or)
- ☒ Copies by **fax**
- ☐ Copies to be picked-up
- ☐ Other_____

For the following purpose(s):

- ☒ Continuity of care/Treatment
- ☐ Legal/Attorney
- ☐ Personal/Patient Request
- ☐ Insurance
- ☒ **Transfer Of Care**
- ☐ Other_____

Documents to be disclosed/released:

Initial as appropriate

- ☐ _____ Alcohol/Drug Treatment
- ☐ _____ STD, HIV & AIDS
- ☐ _____ Sexual Assault
- ☐ _____ Child/Elder Abuse/Neglect
- ☐ _____ Mental Health
- ☐ _____ Reproductive Health

- ☐ **Hospital Records**
- ☐ **Clinic Records**

Type of Records being released/requested:

_____

_____

_____

DOS: _____

SPECIALIST/HOSPITAL

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I understand that information disclosed pursuant to this authorization could be redisclosed by the recipient and that such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal law (HIPAA).

Completion of this document authorizes the disclosure and/or use of health information about you. Please be sure to provide all information requested, failure to do so may invalidate this authorization.

PATIENT INFORMATION:

Patient Name:		Last 4 of SS#:
Address:	City:	State:
Zip Code:	Telephone:	Date of Birth:

I HEREBY REQUEST AND AUTHORIZE:

Name: **MODOC MEDICAL CLINIC**

Address: P.O. BOX 190, 1111 N NAGLE ST	City: ALTURAS	State: CA	Zip Code: 96101
Telephone: 530-708-8820	Fax: **530-233-4302**		

CHECK ONE BOX: ☐ To **release** to ☒ To **request** from

Name:			
Address:	City:	State:	Zip Code:
Telephone:	Fax:		

In the following manner:

- ☒ Copies by mail (or)
- ☒ Copies by **fax**
- ☐ Copies to be picked-up
- ☐ Other_____

For the following purpose(s):

- ☒ Continuity of care/Treatment
- ☐ Legal/Attorney
- ☐ Personal/Patient Request
- ☐ Insurance
- ☐ Transfer Of Care
- ☐ Other_____

Documents to be disclosed/released:

Initial as appropriate

- ☐ _____ Alcohol/Drug Treatment
- ☐ _____ STD, HIV & AIDS
- ☐ _____ Sexual Assault
- ☐ _____ Child/Elder Abuse/Neglect
- ☐ _____ Mental Health
- ☐ _____ Reproductive Health

- ☐ **Hospital Records**
- ☐ **Clinic Records**

Type of Records being released/requested:

_____

_____

_____

DOS: _____

This authorization will expire on:

☐ **Twelve months from date signed** **or** ☐ **Other**_____

My authorization is given freely with the understanding that:

- I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that my revocation is in writing.
- I have the right to receive a copy of this authorization.
- It is my right to be free from retaliation or other penalty for failing to sign the authorization.
- This authorization is valid for a 12-month period from the date it is signed, unless otherwise specified above.
- A photocopy or fax of this authorization is as valid as the original.
- Modoc Medical Center, its directors, officers, employees, agents and volunteers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- Substance Abuse Records are covered by 42 CFR Part 2, Which prohibits further disclosure of the information for which this release has authorized.
- Provider must release records within 15 business days of receiving a valid written request.
- I understand that I may be charged a reasonable fee for the costs of labor for copying, postage, supplies as permitted by HIPAA Privacy Rule and state law.
- I attest that the use of disclosure of PHI that I am requesting is not for a purpose prohibited by the HIPAA Privacy Rule at 45 CFR 164.502(a)(5)(iii).

_____ _____

Signature of Patient or Authorized individual Date

_____

Print Name

_____

If signed other than patient, please indicate relationship

(Verification of identity and/or authority to act on patient's behalf will be required.)