STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320

April 30, 1991

TO: All County Welfare Directors
All County Administrative Officers

Letter No.: 91-40

SUBJECT: FORM MC 220 (12/90), AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

FORM MC 220A (8/90), AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION--AIDS

REFERENCE: Electronic Mail System (EMC2) Message Number DHS 90094

The purpose of this All County Welfare Director's Letter is to inform you that both forms MC 220, Authorization for Release of Medical Information and MC 220A, Authorization of Release of Medical Information--Aids have now been revised (a copy of the revised MC 220 and MC 220A is enclosed).

In the past, the medical community, as well as, various Spanish organizations have expressed concerns regarding the format of the previous MC 220 (10/86) and MC 220A (3/89). The previous forms had an English version on one side and the Spanish version on the reverse side. However, the instruction stated that the English side must be completed and signed by all applicants. This created a problem for the Spanish speaking population. They were uncomfortable about signing on the English side which they could not read. On the other hand, if a Spanish speaking person was allowed to sign on the Spanish side, some medical providers would not release the information claiming their inability to read Spanish.

In order to alleviate the confusion, the forms were revised to have the English and the Spanish interpretation written side by side on the same page. We feel that the revised form is more concise and easier to understand. The revised forms should be satisfactory to both the English and Spanish speaking population.

This is also a reminder that a signed MC 220 or MC 220A (where appropriate) is required for <u>each</u> treatment source or agency that is listed in the MC 223 with the exception of Social Security. All areas of the MC 220 and MC 220A must be completed by the applicant or his/her representative. Disability Evaluation Division will return any incomplete applications.

The earlier information on the MC 220A that was forwarded to the counties via EMC2 message (number DHS 90094) dated July 17, 1990 is now obsolete.

Please begin using the revised version of the two forms. The forms you should now use are MC 220 (12/90) and MC 220A (8/90). Both forms are available in the State warehouse. Please order the forms immediately and, upon receipt of the new forms, destroy the old MC 220 (10/86) and MC 220A (3/89).

You can order the revised MC 220 (12/90) and MC 220A (8/90) forms by completing the "Order Form" DHS 2031 (9/89). In order to request these forms from the State warehouse, the DHS 2031 must be submitted to Department of Health Services Warehouse, 1037 North Market Boulevard, Suite 9, Sacramento, CA 95834.

If you have any policy questions, please contact Marie Taketa at ATSS 467-7156/ (916) 327-7156.

Sincerely,
ORIGINAL SIGNED BY

FRANK S. MARTUCCI, CHIEF
Medi-Cal Eligibility Branch

Enclosures

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

AUTORIZACION PARA PROPORCIONAR INFORMACION MEDICA

Name of Applicant/*Nombre del Solicitante* _____

Social Security Number/*Número del Seguro Social* _____

I.D. Number/*Número de Identificación* _____

(Hospital, Clinic, VA, or WCAB)/*(Hospital, Clínica, Administración de Veteranos, o WCAB)*

I authorize _____
Autorizo a

to disclose my medical records or other information for the period beginning _____ and ending _____
que revele mis antecedentes médicos u otra información sobre el período de Date/*Fecha* *a* Date/*Fecha*

to the state agency that will review my application for disability benefits under the Social Security Act.
a la dependencia estatal que revisará mi solicitud para beneficios por incapacidad bajo la Ley del Seguro Social.

I authorize a private photocopy company to photocopy such medical records as are needed as evidence in determining my eligibility for such benefits. I have been informed that the private photocopy company will not release any information about me to any person or agency other than the state agency indicated above.

This consent can be withdrawn at anytime; however, it will remain valid for any action taken prior to the request being withdrawn. The duration of this consent shall not be any longer than is reasonably necessary to accomplish the purpose for which it was given, i.e., the final determination of my application for disability benefits (including the appeals process). This consent will then automatically expire without any written request.

I consent to the release of the results of any alcohol and/or drug abuse treatment, and/or psychiatric records under the same conditions as outlined above. I understand that such information cannot be released without my specific consent, except in special circumstances.

I have read the above and fully understand its contents in its entirety and have asked questions about anything that was not clear to me and am satisfied with the answers I have received. I understand that I have the right to receive a copy of this authorization on request.

Autorizo a un negocio privado de fotocopiado para que saque copias fotostáticas de los antecedentes médicos que sean necesarios presentar como pruebas para determinar mi elegibilidad para tales beneficios. Se me informó que el negocio privado de fotocopiado no divulgará ninguna información mía a ninguna persona o dependencia que no sea la dependencia estatal que se indica arriba.

Este consentimiento puede ser retirado en cualquier momento; sin embargo, permanecerá en vigor con respecto a cualquier acción que se haya ejercitado antes que se retirara la petición. La vigencia de esta petición, no durará más que lo razonablemente necesario para llevar a cabo el asunto para el cual se dio; esto es, la determinación final de mi solicitud para beneficios de incapacidad (incluyendo el procedimiento de apelaciones). Entonces, este consentimiento expirará automáticamente sin pedirlo por escrito .

Autorizo que los resultados de la prueba para detectar los tratamientos relacionados con el abuso del alcohol y/o drogas, y los expedientes siquiátricos para que sean proporcionados bajo las mismas condiciones que se indican arriba. Entiendo que tal información no puede proporcionarse a menos que dé mi consentimiento expreso, excepto en circunstancias especiales.

He leído y entiendo perfectamente la información que aparece arriba. He hecho preguntas sobre dudas que tenía y estoy satisfecho con las aclaraciones que me proporcionaron. Entiendo que tengo el derecho de recibir una copia de esta autorización, si así lo deseo.

_____ _____
Signature of Applicant/*Firma del Solicitante* Date/*Fecha*

_____ _____
Signature of Person Acting in Behalf/*Firma de la Persona que lo Representa* Date/*Fecha*

_____
Street Address/*Dirección*

_____ _____
City/*Ciudad* ZIP Code/*Zona Postal* Telephone/*Teléfono*

To Whom it May Concern: Medical reports released to the state's Disability Evaluation program become part of the applicant's file subject to the provisions of the Federal Privacy Act of 1974 which provides that, upon request, an applicant may have access to those records. A condition of access to medical records is that, at the time access is requested, the applicant must designate a representative to receive, review, and discuss them with the applicant. It is recommended, but not required, that the representative be a physician or other health service professional.

A Quien Corresponda: Los expedientes médicos proporcionados por el programa estatal de Evaluación de Incapacidades (Disability Evaluation) forman parte del expediente del solicitante de acuerdo a lo estipulado por el Acta Federal de Confidencialidad de 1974 que establece que el solicitante puede tener acceso a esos expedientes si así lo solicita. Una condición para obtener acceso a los expedientes médicos será que, al hacerse la solicitud, el solicitante debe nombrar a un representante para que los reciba, examine, y lo repase con el solicitante. Es recomendable, pero no obligatorio, que el representante sea un médico u otro profesional en el ramo de la salud.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION -- AIDS
AUTORIZACION PARA PROPORCIONAR INFORMACION MEDICA -- SIDA (AIDS)

Name of Applicant/*Nombre del Solicitante* _____

Social Security Number/*Número del Seguro Social* _____

I.D. Number/*Número de Identificación* _____

(Hospital, Clinic, VA, or WCAB)/*(Hospital, Clínica, Administración de Veteranos, o WCAB)*

I authorize
Autorizo a _____

to disclose my medical records or other information for the period beginning _____ and ending _____
que revele mis antecedentes médicos u otra información sobre el período de Date/*Fecha* *a* Date/*Fecha*

to the state agency that will review my application for disability benefits under the Social Security Act.
a la dependencia estatal que revisará mi solicitud para beneficios por incapacidad bajo la Ley del Seguro Social.

I authorize a private photocopy company to photocopy such medical records as are needed as evidence in determining my eligibility for such benefits. I have been informed that the private photocopy company will not release any information about me to any person or agency other than the state agency indicated above.

This consent can be withdrawn at anytime; however, it will remain valid for any action taken prior to the request being withdrawn. The duration of this consent shall not be any longer than is reasonably necessary to accomplish the purpose for which it was given, i.e., the final determination of my application for disability benefits (including the appeals process). This consent will then automatically expire without any written request.

I consent to the release of the results of the human immunodeficiency virus (HIV) antibody test and any other indicators of immune status and medical records and information pertaining to the treatment of AIDS or ARC (AIDS-related complex), alcohol and/or drug abuse treatment, and/or psychiatric records under the same conditions as outlined above. I understand that such information cannot be released without my specific consent, except in special circumstances.

I have read the above and fully understand its contents in its entirety and have asked questions about anything that was not clear to me and am satisfied with the answers I have received. I understand that I have the right to receive a copy of this authorization on request.

Autorizo a un negocio privado de fotocopiado para que saque copias fotostáticas de los antecedentes médicos que sean necesario presentar como pruebas para determinar mi elegibilidad para tales beneficios. Se me informó que el negocio privado de fotocopiado no divulgará ninguna información mía a ninguna persona o dependencia que no sea la dependencia estatal que se indica arriba.

Este consentimiento puede ser retirado en cualquier momento; sin embargo, permanecerá en vigor con respecto a cualquier acción que se haya ejercitado antes que se retirara la petición. La vigencia de esta petición, no durara más que lo razonablemente necesario para llevar a cabo el asunto para el cual se dio; esto es, la determinación final de mi solicitud para beneficios de incapacidad (incluyendo el procedimiento de apelaciones). Entonces, este consentimiento expirara automáticamente sin pedirlo por escrito .

Autorizo que los resultados de la prueba para detectar los anticuerpos del virus de inmunodeficiencia humana (VIH) *(HIV - human immunodeficiency virus)*, cualesquier otros agentes infecciosos de inmunidad, antecedentes médicos, información relacionada con el tratamiento del SIDA (*AIDS*) o de la condición o complejo relacionado al SIDA (CRS) *(ARC - AIDS-related complex)*, tratamientos relacionados con el abuso del alcohol y/o drogas, y los expedientes siquiátricos para que sean proporcionados bajo las mismas condiciones que se indican arriba. Entiendo que tal información no puede proporcionarse a menos que dé mi consentimiento expreso, excepto en circunstancias especiales.

He leído y entiendo perfectamente la información que aparece arriba. He hecho preguntas sobre dudas que tenía y estoy satisfecho con las aclaraciones que me proporcionaron. Entiendo que tengo el derecho de recibir una copia de esta autorización, si así lo deseo.

_____ _____
Signature of Applicant/*Firma del Solicitante* Date/*Fecha*

_____ _____
Signature of Person Acting in Behalf/*Firma de la Persona que lo Representa* Date/*Fecha*

_____
Street Address/*Dirección*

_____ _____ _____
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