

**AUTHORIZATION TO RELEASE MEDICAL, PSYCHIATRIC, ALCOHOL,
DRUG ABUSE RECORDS, HIV RELATED INFORMATION**

PATIENT INFORMATION :

Patient/Client Name _____

DOB _____ SSN _____ Telephone _____

Maiden Name/Other Name Used in the Past _____

Dates of treatment covered by this authorization: From _____ To _____

EXPLANATION:

This authorization conforms to requirements of State and Federal laws governing release and receipt of Protected/Patient Health Information (PHI).

AUTHORIZATION:

I hereby authorize the following healthcare provider/agency to disclose information from my records to the recipient(s) listed below, even though such information is otherwise confidential and/or privileged.

FROM: Name _____
Address _____
City, State, Zip Code _____

TO WHOM: Name _____
Address _____
City, State, Zip Code _____

PURPOSE(S):

State reason records are being requested Personal Records Continuing Health Care
Other (please describe, be specific) _____

I would like to: View, Receive a Copy, Receive a Summary, of the following:

INFORMATION WHICH MAY BE RELEASED:

Disclosure shall be limited to the following types of information. Check all that apply.

- | | |
|--|-----------------------------|
| Evaluations/Assessments/Treatment Plans | Lab Reports |
| Inpatient Records | Outpatient Records |
| Children's Services Records (of an adult client) | Crisis Records |
| Financial Records | Prescription/Medication Log |
| ASAM Results | Drug Testing Results |
| Other (Please be specific) _____ | |

Attached form to be completed (Please specify form) _____

I give special authorization to release any information regarding:

Substance Abuse

HIV Information

Psychiatric/Mental Health

EXCEPTION(S): Information That You Do Not Want Released (be specific): _____

I understand that such information cannot be released without my special consent, except when required by law and that all restrictions contained in this authorization as to use, transfer, or disclosure of such information apply to such records.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to San Joaquin County Behavioral Health Services. I understand that the revocation will not apply to information that has already been released in response to this authorization.

DATE OF EXPIRATION *: _____

*This authorization expires one year from date signed or as otherwise specified.

PROHIBITION ON USAGE, TRANSFER, OR REDISCLOSURE OF INFORMATION:

Except as required by state or federal laws, use of information released for other than the stated purpose or redisclosure or transfer of this information to any person or entity not named herein is prohibited. An additional written authorization must be obtained for any proposed new use of the information or its redisclosure or transfer of such information. Authorized information may be subject to redisclosure by the recipient and no longer protected by the privacy regulations.

RIGHT OF CLIENT TO RECEIVE A COPY OF AUTHORIZATION:

I understand that I have the right to receive a copy of this signed authorization.

I have received a copy of this authorization. Yes No

I understand that authorizing the use or disclosure of the information identified above is voluntary. San Joaquin County Behavioral Health Services will not condition treatment, payment, enrollment, or eligibility of benefits on whether I sign this authorization.

_____ Date _____

Signature of patient/client or legal representative

If signed by legal representative, authority/relationship to patient _____

Witness _____

MINORS: By federal regulations in drug/alcohol abuse or HIV/AIDS related material both patient/client and parent, guardian or other person authorized to act by state law in his/her behalf is required.

Exceptions: Where minor may consent to treatment by state law, only minor must sign.