San Bernardino County Department of Behavioral Health
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Client Name: _____ Date of Birth: / / *(Month/Date/Year)*

Client Address: _____ Last 4 digits SSN: XXX / XX / _____

_____ Client Phone: ( ) _____

Completion of this document authorizes the release and use of your health information. Failure to provide all information requested may invalidate this Authorization.

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize _____ to release to:
(Facility Name/Provider/Other)

Name: _____
(Person/Organization authorized to receive health information)

Address: _____

_____

City, State, Zip: _____

Phone Number: ( ) _____ Fax Number: ( ) _____

a. I specifically authorize release of the following information *(check as appropriate)*:

☐ Mental Health treatment information _____ *(client or legal representative's initials)*
☐ Alcohol/Drug treatment information _____ *(client or legal representative's initials)*

b. I authorize release of:

☐ All my health information pertaining to my medical history, mental health condition and treatment received; from_____ to_____ OR
☐ Only the following records or types of health information; from_____ to_____

☐ Assessment ☐ Client Plan ☐ Summary Letter ☐ Attendance ☐ Treatment Notes
☐ Discharge Summary ☐ Diagnosis ☐ Medication ☐ Other _____

PURPOSE

Purpose of requested use or disclosure: ☐ client request; OR ☐ other *(please list purpose)*:

_____

Limitations, if any: _____

_____

EXPIRATION

This Authorization expires *[insert exact date]*: _____

Note: California law requires you enter an exact date; otherwise, DBH cannot process this Authorization.

REVOCATION

I understand that I may cancel this Authorization at any time, but I must do so in writing by submitting my request for revocation to the health care facility that I authorized to release my health information. If I revoke this Authorization, I must submit to the following address: _____.

(Insert the address of the DBH Clinic authorized to disclose or use the client's health information)

My cancellation of this Authorization will take effect upon receipt by DBH and no further information will be released based on the cancellation. I understand that DBH may not be able to retrieve any information that has already been released prior to the revocation.

MY RIGHTS

- I may refuse to sign this Authorization. My refusal to sign will not affect my ability to get treatment, payment or eligibility for benefits.
- I have a right to receive a copy of this Authorization.
- To the extent permitted by law, I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I understand the health information I authorized for release could be re-disclosed by the person/entity I designated to receive the information. I understand DBH cannot prevent my information previously released by this Authorization from being re-released by whoever received it.
- I understand in some cases California law does not prohibit the re-release of my information and my information may no longer by protected by federal confidentiality law (HIPAA). However, I understand California law prohibits the person or entity receiving my health information from making additional disclosures unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNATURE

Date: _____ Time: _____ ☐ am ☐ pm

Signature: _____

(DBH client shall sign, including minor age 12 and up, if having legal and mental capacity)

Signature: _____

(legal representative of client or parent/guardian for minors not having capacity to consent)

If signed by someone other than the client, state your name and legal relationship to the client:

_____

(Name and relation to client)

FOR USE BY DBH CLINICAL STAFF ONLY

I have assessed this 12-17 year old minor and determined ☐ he/☐ she ☐ does/☐ does not have capacity to authorize the release of his/her protected health information.

Licensed DBH Staff Signature	Printed Name	Date