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

Name of Client: _____	Date of Birth: ___/___/____(Month/Date/Year)
Gender: ☐ Male ☐ Female	Social Security: XXX - XX - ____ (last 4 digits only)

Completion of this document authorizes the release, disclosure, and/or use of health information about you. Failure to provide all information requested may invalidate this Authorization.

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Department of Behavioral Health to release to:
(Facility Name/Provider/Other)

(1) Name: Human Services Administration
Address: 150 South Lena Road, San Bernardino, CA 92415-0515
Phone/Fax Number 909-388-0278 phone / 909-388-0233 fax

and

(2) Name: Children's Fund
Address: 825 E Hospitality Lane, Second Floor, San Bernardino, CA 92415-0132
Phone Number 909-387-4949 phone / 909-383-9755 fax

and

(3) Name: Human Services Auditing Division
Address: 825 E. Hospitality Lane, First Floor, San Bernardino, CA 92415-0132
Phone/Fax Number 909-383-9600 phone / 909-383-9610 fax

The following information:

a. ☒ Minor or transitional youth's personally identifiable information and/or protected health information such as name, address, telephone number, date of birth, gender, ethnicity, DBH identification number and parent/guardian's name related to an immediate need voucher received.

PURPOSE

Purpose of requested use or disclosure: ☐ patient request; *OR* ☒ other:

The information shall be provided for the purpose of tracking and auditing immediate need vouchers.

To Agencies Receiving This Information: This information is protected by state and federal laws and should not be given to anyone else not included on this Authorization without a new Authorization from the client, unless otherwise authorized by law. If you have received alcohol and/or drug assessment, treatment, or referral program information, the following applies: This information has been disclosed to you from records protected by Federal confidentiality law/rule (42 CFR, Part 2). The Federal rules forbid you from making another/any further release/disclosure of this information unless

expressly/specifically permitted by the written consent of the person signing this Authorization or as allowed by Federal law/rule (42 CFR, Part 2). A general Authorization of medical or other information is NOT sufficient for this purpose. The Federal laws/rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

EXPIRATION

This Authorization expires [insert date]: _____

Note: California law requires you enter a specific date. If a specific date is not entered, DBH cannot process your request as indicated on this Authorization.

MY RIGHTS

- I may refuse to sign this Authorization. It will not affect my ability to get treatment but will affect my ability to receive a voucher.
- 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 may revoke this authorization at any time, but must do so in writing and submit it to the following address: _____

_____

My revocation will take effect upon receipt, however, if this Authorization has already been processed the information cannot be rescinded but no further information will be released based on the revocation. Information released by this Authorization could be re-released by whoever receives it, and the re-release is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

SIGNATURE

Date: _____ Time: _____ ☐ am ☐ pm

Signature: _____
(patient/ legal representative/spouse/financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient:

_____
(Name and relation to client)

Witness Signature: _____

_____
(Name and relation to client)