



AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Client Name _____ DOB _____
 Client Address _____ Last 4 Digits of SSN _____
 _____ Client Phone # _____

Completion of this document authorizes the release and use of your PHI. Failure to complete all applicable sections of the form may invalidate this Authorization.

I. AUTHORIZATION TO RELEASE PHI

(A) I hereby authorize _____
(Facility name/Provider name/Other)

(B) To release to (Enter name of individual(s) or Entity(ies) in the section below and specify relationship by answering questions i and ii)

Individual(s) or Entity(ies) Name(s): _____

Two-Way Authorization

Checking Box authorizes the two-way exchange of your PHI between parties identified in Sections I (A) and I (B) of this Authorization.

(C) Indicate the relationship:

(i) Is this a Treating Provider Entity? - Yes No

(ii) Is this a Third-Party Payer? Yes No

(This is an entity with no Treating Provider relationship, but is a Third-Party Payer)

(D) If the entity(ies) named in Section (B) facilitates the exchange of health information (HIE) or is a research institution, you must check and complete the information for one of the boxes below (required only for SUD disclosures)

(i) Named individual participant _____
(e.g. John Smith)

(ii) General designation of individual or entity or class of participants with a treating provider relationship

(e.g. My treatment team in the Inland Empire Health Information Exchange (HIE))

II. MENTAL HEALTH SPECIFIC

(E) I specifically authorize release of the following **Mental Health** treatment Information

(Client or legal representative's initials)

(F) I authorize the release of either:

(i) All my health information pertaining to my medical history and/or mental health condition

Dates From _____ **To** _____ **OR**

(ii) Only the following specific records or types of medical history and/or mental health information

Dates From _____ **To** _____

- | | | |
|--|--|---|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Attendance | <input type="checkbox"/> Client Plan |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Psych Clearance | <input type="checkbox"/> Summary Letter |
| <input type="checkbox"/> Treatment Notes | <input type="checkbox"/> Other _____ | |

III. SUD SPECIFIC

(G) I specifically authorize release of the following specific records or types of **SUD** Treatment information

(Client or legal representative's initials)

Dates From _____ **To** _____

- | | | |
|--|--|---|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Attendance | <input type="checkbox"/> Client Plan |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Psych Clearance | <input type="checkbox"/> Summary Letter |
| <input type="checkbox"/> Treatment Notes | <input type="checkbox"/> Other _____ | |

IV. PURPOSE OF MENTAL HEALTH AND/OR SUD DISCLOSURE

Purpose of requested use or disclosure:

(H) Client request OR Other (please list purpose) _____

List limitations of disclosure, if any:

V. EXPIRATION (MENTAL HEALTH)

This Authorization expires (*insert exact date*): _____

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

VI. REVOCATION (MENTAL HEALTH)

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 my written request to the following address:

(I) Name of Facility/
Provider/ Other _____

Address _____

City, State, ZIP _____

Code, _____

Phone Number _____

Fax Number _____

My cancellation of this Authorization takes effect upon receipt by DBH who will release no further information based on the cancellation. I understand that any information DBH released prior to the revocation may be irretrievable.

VII. MY RIGHTS (MENTAL HEALTH)

- 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 be 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.

VIII. EXPIRATION (SUD)

Unless I revoke Authorization earlier, Authorization will expire automatically as follows:

Describe date, event, or condition upon which consent will expire, which must not be longer than reasonably necessary to serve the purpose of this consent

IX. REVOCATION (SUD)

I understand that I may cancel this Authorization at any time, but I must do so either verbally, or 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 in writing, I must submit my written request to the following address:

(J) Name of Facility/
Provider/ Other
Address

City, State,
ZIP Code

Phone #

FAX #

My cancellation of this Authorization takes effect upon receipt by DBH who will release no further information based on the cancellation. I understand that any information DBH released prior to the revocation may be irretrievable.

Note: If an SUD Authorization is revoked verbally, the revocation shall be immediately documented in the client's medical record. Whenever an Authorization is revoked verbally, an effort shall be made to obtain the revocation in writing.

X. MY RIGHTS (SUD)

- I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Sections 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.
- I understand that I might be denied service if I refuse to consent to a disclosure for purpose of treatment, payment, or health care operations, if permitted by state law.
- I will not be denied services if I refuse to consent to a disclosure for other purposes.
- I will be provided a copy of this form.

X. MY RIGHTS (SUD), continued

- If I select a “general designation” to allow all my treating providers to receive specified information, I understand I have the right to obtain a list of disclosures. If a request is made in writing (within two (2) years of disclosure) thirty (30) days from the date the written request is received; list of disclosure shall contain name of entity disclosure was made to, date of disclosure, and brief description of identifying information released.

XI. MAILING ADDRESS FOR RECORDS

Note: Complete this section only if records are to be mailed/faxed to receiving party.

(I) Name of Recipient _____

Address _____

City, State,
ZIP Code _____

Phone # _____

FAX # _____

XII. SIGNATURE

Date: _____ Time: _____ a.m. p.m.

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)

Note: If signed by someone other than the client, state your name and legal relationship to the client (MUST provide legal documentation to support the legal relationship).

XIII. NOTICE PROHIBITING RE-DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION

Title 42 Code of Federal Regulations Part 2 prohibits unauthorized disclosure of these records.

Note: This form must be given to every individual and/or entity provided with SUD treatment information)

English

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call [1-888-743-1478] (TTY: [711]).

ATTENTION: Auxiliary aids and services, including but not limited to large print documents and alternative formats, are available to you free of charge upon request.

Call 1 (888) 743-1478 (TTY: 7-1-1).

Español (Spanish)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al [1-888-743-1478] (TTY: [711]).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số [1-888-743-1478] (TTY: [711]).

Tagalog (Tagalog–Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa [1-888-743-1478] (TTY: [711]).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. [1-888-743-1478] (TTY: [711])번으로 전화해 주십시오.

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 [1-888-743-1478] (TTY: [711])。

Հայերեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆՆԵՐԷՆ Եթե խոսում եք հայերեն, սպա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Չանգահարեք [1-888-743-1478] (TTY (հեռատիպ) [711]):

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните [1-888-743-1478] (телетайп: [711]).

فارسی (Farsi)

شما برای رایگان بصورت زبانی تسهیلات کنید، می گفتگو فارسی زبان به اگر توجه بگیرد تماس (TTY: [711]) [1-888-743-1478] با باشد می فراهم

日本語 (Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。[1-888-743-1478] (TTY: [711]) まで、お電話にてご連絡ください。

Hmoob (Hmong) LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau [1-888-743-1478] (TTY: [711]).

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਧਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਨੂੰ ਮੇਰੇ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। [1-888-743-1478] (TTY: [711]) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)

[1-888-743-1478] برقم اتصل. بالمجان لك تتوافر اللغوية المساعدة خدمات فإن اللغة، اذكر تتحدث كنت إذا: ملحوظة ([711] :والبكم الصم هاتف رقم) .

हिंदी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। [1-888-743-1478] (TTY: [711]) पर कॉल करें।

ภาษาไทย (Thai)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร [1-888-743-1478] (TTY: [711]).

ខ្មែរ (Cambodian)

ប្រយ័ត្ន: អ្នកនិយាយភាសាខ្មែរ, រសវាជំនួយមនុស្សភាសា រោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូល ទូរស័ព្ទ [1-888-743-1478] (TTY: [711])។

ພາສາລາວ (Lao)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ [1-888-743-1478] (TTY: [711]).