County of Placer

COUNTY OF PLACER

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient/Client Identifying Information		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
STREET ADDRESS:	CITY/STATE:	ZIP CODE:
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	CASE NUMBER:

Person/Organization Providing Information *[45 CFR § 164.508 (c) (ii) & Civ. Code § 56.11(c)]*	Person/Organization Receiving Information *[45 CFR § 164.508 (c) (ii) & Civ. Code § 56.11(f)]*
NAME:	NAME:
STREET ADDRESS:	STREET ADDRESS:
CITY/STATE/ZIP:	CITY/STATE/ZIP:
PHONE: FAX	PHONE FAX:

Detailed Description of What Kind of Information To Be Released

[45 C.F.R.. § 164.508(c)(ii) & Civ. Code § 56.11(d)& (g)]

☐ Entire Record
☐ Medical Records Only
☐ Mental Health Records Only
☐ HIV/AIDS Test Results
☐ Social/Medical/Legal History
☐ Treatment Attendance/Participation
☐ Seclusion Restraint Information
☐ Individual Treatment Plan
☐ Immunization Records Only
☐ Other: _____

☐ Diagnosis (specify): _____
☐ Evaluation/Assessment (specify, e.g.: bio-social, psychological, psychiatric):
☐ Test/Testing Results (specify, e.g.: labs, X-rays, EKG, psychological, urinalysis):

Relevant Dates, if known:

I authorize this release to include information on services I have received for:

☐ Mental Health ☐ Substance Abuse ☐ HIV/AIDS ☐ Genetic Testing

NAME. **CASE NUMBER:**

Detailed Description of How Information Will Be Used:
(Examples: Evaluating; Monitoring Progress or Participation; Planning Treatment! Case Management; Assessing Services; Patient/Client Request) *[45 C.F.R. § 164.508* (C) *(iv)]*

This Authorization will expire on: _____ __(date)
[45 C.F.R. 164.508(c)(v) & Civ. Code § 56.11(h)]

I understand my rights:

- I authorize the disclosure of my health information as described above for the purpose(s) listed. This *Authorization* is voluntary, as I understand my health information is subject to Federal and State privacy regulations. *[45 CFR § 164.508(c)(2)(i)]*

- I have the right to revoke this *Authorization* in writing to the provider of this information listed above. The *Authorization* will stop on the date my request is received, except for action already taken, or if this *Authorization* was obtained as a condition of insurance, enrollment, or eligibility. [45 *C.F.R. § 164.508(c)(2) (ii)& Civ. Code § 56.11(h)]*

- I understand the *Notice of Privacy Practices* provides instructions, should I choose to revoke my *Authorization. [45 C.F.R. § 164.508(c) (ii)]*

- I understand that I am signing this *Authorization* voluntarily and that treatment, payment or eligibility for my benefits will not be affected if I do not sign this *Authorization* unless my treatment, enrollment in a health plan or eligibility for benefits are conditioned on me signing the *Authorization. [45 C.F.R. § 164.508(c) (2) (ii)]*

- I understand if the organization I have authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by Federal privacy regulations. *[45 C.F.R. § 164.508 (c)(2) (iii)]*

- I understand I have the right to receive a copy of this *Authorization.*

Signature of Patient/Client:	Date:

Photocopy of this *Authorization* shall have the same meaning as the original.

Signature of Parent, Guardian, Conservator, or Legal Representative (indicate relationship):	Date: