



1006 – AUTHORIZATION FOR DISCLOSURE OF INFORMATION

Client Name (Last, First) _____ DOB: _____

Address: _____ Phone: _____

Failure to provide all information requested on this form may invalidate this authorization.

USE AND DISCLOSURE OF HEALTH INFORMATION:

I hereby authorize DHHS-Behavioral Health Branch to:

DISCLOSE TO **REQUEST FROM** **VERBAL EXCHANGE ONLY**

NAME OF INDIVIDUAL AND ORGANIZATION:

Individual: _____

Organization: _____

Address: _____

City, State: _____

Phone: _____

OR

___ Initial here and check below
to indicate review of attachment
for multiagency authorization:

FIT/RAC	SUD
Regional Facility	TAY
HBTW	TBS

DISCLOSURE IS REQUIRED FOR:

- | | |
|---|---|
| <input type="checkbox"/> My Personal Records | <input type="checkbox"/> Applying for and maintaining Financial Assistance/Benefits |
| <input type="checkbox"/> Legal Representation | <input type="checkbox"/> Sharing with other Health Care Providers |
| <input type="checkbox"/> Program Evaluation | <input type="checkbox"/> Coordination of Treatment and/or Placement |
| <input type="checkbox"/> Other (specify): _____ | |

INFORMATION TO BE DISCLOSED (check all that apply):

I authorize the release of my records dated from _____ to _____.

Outpatient records *Inpatient records*

*** INITIALING AT LEAST ONE LINE BELOW IS REQUIRED***

___ Behavioral / Physical Health ___ HIV Related Information ___ Substance Use Disorder(SUD)

- | | | |
|--|--|---|
| <input type="checkbox"/> Assessment(s) | <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Treatment Plans and Updates |
| <input type="checkbox"/> Psychological Evaluations | <input type="checkbox"/> Psychiatric Evaluations | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> Progress Notes/History | <input type="checkbox"/> Placement Documentation | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> School Records _____ | <input type="checkbox"/> Court/Police Records |
| <input type="checkbox"/> Allergies & Immunizations | <input type="checkbox"/> Medication List | <input type="checkbox"/> Placement Issues and Updates |
| <input type="checkbox"/> CANS Assessments | O Other specific information _____ | |

Client Name: _____ DOB: _____ Client ID: _____

EXPIRATION OF AUTHORIZATION:

This authorization will expire on _____ or automatically one year after signing.
Date

NOTICE OF RIGHTS AND OTHER INFORMATION:

By signing this authorization I understand that:

- This authorization is voluntary and I do not need to sign in order to receive treatment, enroll in services, or for payment for my health care.
- I have a right to receive a copy of this authorization and receive a list of disclosures within the last six years. A copy of this authorization is as valid as the original.
- This authorization is effective immediately. I may revoke this authorization at any time. I understand revocation must be in writing, signed by me or on my behalf and delivered to the records department. Revocation will not apply to information that has already been released in response to this authorization.
- Entities that receive my health information under this authorization may not be required to follow the same privacy rules as the entity that shared the information and could redisclose my health information. However, if information related to substance abuse disorders or HIV/AIDS treatment is shared, that information cannot be re-disclosed except with another authorization.
- Sharing of my health information shall be consistent with all state and federal regulations concerning protection of juvenile records.
- Substance use disorder record requirements prohibit the information obtained in response to this authorization to be used for prosecution against me and cannot be redisclosed without the patient's consent, except under specific circumstances outlined in regulation 42 CFR Part 2.

SIGNATURES:

_____	_____	_____
Print Name	Signature	Date

If signed by Client's Legal Representative, state relationship and authority to do so:

Youth Signature: _____

Date

Witness Signature (required when only minor is signing to disclose records): _____

Date

_____	_____	_____
Print Name	Signature	Date

Legal documentation may be required to verify that you are the parent, conservator, guardian, executor of a decedent's will or have medical decision-making authority for the client.

This release complies with CA WIC, §5328 for LPS Protected Records, 42 U.S.C. §290dd-3 & CFR, Part 2, Substance Abuse Regulations & Confidentiality of Medical Info Act, CC § 56 et seq, & H&S code § 120775 et seq, and HIPAA Privacy Stds see 45 CFR §164.508)