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[1]:	DATE OF BIRTH:	CASE NUMBER:
AVATAR NUMBER [1]:		

Person/Organization Providing Information *[45 C.F.R.§ 164.508(c)(ii) & Civ. Code § 56.11(c)]*		**Person/Organization Receiving Information** *[45 C.F.R.§ 164.508(c)(iii) & Civ. Code § 56.11(f)]*	
NAME: ☐ Check if a 42 CFR Part 2 Provider[2]		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)(i)& Civ. Code § 56.11(d) & (g)]]*	
☐ Entire Record	☐ Diagnosis (specify): _________________
☐ Medical Records Only	☐ Treatment Attendance/Participation
☐ Social/Medical/Legal History	☐ Seclusion Restraint Information
☐ Immunization Records Only	☐ Psychotherapy Notes
☐ Mental Health Treatment hx	☐ Individual Treatment Plan
☐ Substance Use Services Treatment hx (Detailed description required-42CFR Part 2)	☐ Evaluation/Assessment (specify, e.g.: bio-social, psychological, psychiatric):
☐ Test/Testing Results (specify, e.g.: X-rays, EKG, labs, psychological, urinalysis):	☐ Other (Please Specify):

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[1] This is not a required field

[2] Any providers that are 42 CFR Part 2 providers, *i.e.*, those that hold itself out or whose primary function is the provision of substance use disorder diagnosis, treatment, or referral for treatment should be expressly identified.

Patient/Client Name:____________________ AVATAR/Case Number:______________

Relevant Dates of Treatment to be Disclosed, if known: To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check mark(s) below indicate(s) that I do **NOT** permit this type of information, if it exists, to be released. I understand that if I do not check in the box, this type of information will be released if it exists. ☐ Mental Health ☐ Substance Abuse ☐ HIV/AIDS ☐ Genetic Testing ☐ Sexually Transmitted Disease
Disclosure:
Information Will Be Disclosed: ☐ Verbally ☐ Records Sent ☐ Both 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 (you must specify a date): _____ *(*date)*
*If a date isn't provided this ROI will automatically expire in 12 months from the date of signature *[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 protected by Federal and State privacy regulations, and cannot be disclosed without my consent except as otherwise specifically provide by law. *[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 previously disclosed information and such disclosed information can be re-released by the recipient of the information because it is no longer protected under Federal law, 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: