



**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 <i>[45 C.F.R. § 164.508(c)(ii) & Civ. Code § 56.11(c)]</i>	Person/Organization Receiving Information <i>[45 C.F.R. § 164.508(c)(iii) & Civ. Code § 56.11(f)]</i>
NAME:	NAME ² :
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)]

<input type="checkbox"/> Entire Record	<input type="checkbox"/> Diagnosis (specify): _____
<input type="checkbox"/> Medical Records Only	<input type="checkbox"/> Treatment Attendance/Participation
<input type="checkbox"/> Social/Medical/Legal History	<input type="checkbox"/> Seclusion Restraint Information
<input type="checkbox"/> Immunization Records Only	<input type="checkbox"/> Psychotherapy Notes
<input type="checkbox"/> Mental Health Treatment hx	<input type="checkbox"/> Individual Treatment Plan
<input type="checkbox"/> Substance Use Services Treatment hx (Detailed description required-42CFR Part 2)	<input type="checkbox"/> Evaluation/Assessment (specify, e.g.: bio-social, psychological, psychiatric):
<input type="checkbox"/> Test/Testing Results (specify, e.g.: X-rays, EKG, labs, psychological, urinalysis):	<input type="checkbox"/> Other (Please Specify):

¹ This is not a required field

² In cases involving the disclosure of substance use information protected by 42 CFR Part 2, an individual's name is required unless the entity is a third-party payer or a treating provider, and in such case an entity can be listed.

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: