

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

By completing this document, you authorize the disclosure and/or use of your protected health information (PHI). Unless otherwise indicated, all sections of this form must be completed in order to be valid.								
LAST NAME:		FIRST NAME:			MIDDLE INITIAL:			
Address:		CITY/STATE:			ZIP CODE:			
Date of Birth:	SS# (optional):			Telephone Number:				
Medical Record # (if known):								
		0	100		•	1.0		
Who is authorized to release your records Name and Address			Who do you want to receive your records? Name and Address					
Description of information to be released								
Complete Physical/Medical Record (excluding protected class information)	Please <i>initial</i> each box that applice Please Please Initial each box that applice Initial each Box that Initial each			DIICS	Prog	ress Notes		
History and Physical Exam	X-Ray Reports				Billin	g Records		
Laboratory Test Results	Immunization Records				Denta	al Records		
Consultation Reports	Other (Specify)				Othe	r (Specify)		

Protected Class Information

Special approval, as required by law, is needed before the protected classes of information can be released. These types of information may or may not be contained in your medical records. The following information *will not* be released, to the extent any record(s) exist, unless you specifically authorize it by *initialing the space below*:

Drug and Alcohol Records		Mental Health Records				
Assessment, diagnosis, and prognosis Urine Test Progress in Treatment Date of Attendance Complete Drug and Alcohol Records HIV Antibody Test Results			Assessment and diagnosis Consultations Psychological Testing Progress Notes Psychiatric Evaluation Complete Mental Health Records			
Dates/	Time Period of Records to	Be Relea	sed			
The records covered by this release include only the records created during the period from (date) to (date) If dates are not specified, this authorization will include the release of all records checked or initialed.						
	Purpose of Disclosure	е				
Treatment or consultation	☐ Patient Request		Other (Specify)			
RIGHT TO CANCEL: I understand that: I have the right to cancel this authorization at any time by sending a notice canceling this authorization to the provider(s) listed on page 1 of this form. Cancellation of this authorization will not apply to information that has already been released based on this authorization.						
EXPIRATION: Unless otherwise cancelled, this authorization will expire on: Completion of this request (one time disclosure). One Year from signature date The specified date: The authorization will be voided on the date of cancellation or expiration, except if action has been taken in reliance on it.						
RE-DISCLOSURE: I understand that Client records disclosed because of the confidentiality regulations (HIPAA). It re-disclosing this information except to Client records released by Solano Contother federal confidentiality regulation	it: his release may be re-disclos However, California state law with your written authorizatior bunty Drug and Alcohol Divisi	sed and no prohibits of or as rec	recipients of these records from quired by or permitted by law.			

OTHER RIGHTS: I understand that:

- Authorizing the disclosure of my records is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or to create health information to provide to a third party. Under no circumstances am I required to authorize the release of mental health records.
- I may inspect or obtain a copy of the information to be used or disclosed.
- I have a right to request a copy of this authorization.
- Fees may be charged for copy services.
- I have authorized the use or disclosure of my individually identifiable health information as described above for the purpose(s) listed.

Signatures							
Client Signature:							
Authorized Represe	ntative Signature:		Date:				
Relationship:	☐ Parent	☐ Guardian	☐ Conservator				
	Other (Specify)			_			
Approval to Disclose	e (to be completed by	Custodian of Records	s):				
☐ Yes ☐ N	lo. If no, state reason						
Clinician Approval, i	f applicable ¹ :						
Revised 5/2/06							

¹ Under certain circumstances, the approval of a physician, licensed psychologist, social worker with a master's degree in social work, or licensed marriage and family therapist, who is in charge of the patient may be required before records may be released.