EL DORADO COUNTY- HEALTH & HUMAN SERVICES AGENCY
MENTAL HEALTH DEPARTMENT

AUTHORIZATION FOR RELEASE OF WRITTEN OR VERBAL HEALTH INFORMATION

CLIENT INFORMATION					
First Name		**Last Name**			
Address				**Date of Birth:**	
City/State/Zip					
E-Mail		**Phone #**			
AUTHORIZATION Client to Initial Box(s)	**Verbal/Written Communication**		**Records Release**		

I HEREBY AUTHORIZE: **(Party Releasing Information)**	TO RELEASE TO: **(Party Receiving Information)**
Name: EL DORADO COUNTY BEHAVIORAL HEALTH	Name:
Role/Relationship: PROVIDER	Role/Relationship:
Address: 768 Pleasant Valley Rd., Ste 201	Address:
City/State/Zip: Diamond Springs, CA 95619	City/State/Zip:
Phone: Medical Records 530-621-6292	Phone:
Fax/Email: 530-303-1526	Fax/Email:

PURPOSE & LIMITATIONS

The purpose of the the requested Authorization is**:** -Client / Guardian Request-

Secondary Purpose (if any):

Limitations/Restrictions:

TYPE OF INFORMATION TO BE RELEASED- Client to Initial Each Box Desired

	Mental Health Information (May include-Medications, Diagnosis, Assessments, Vital Signs, Problem List/Treatment Plan, Progress Notes)		
	Substance Use (Alcohol & Drug) Information		HIV/AIDS Information
	Medical Information		Genetic Testing
	Other:		

Records to be released in below Format-(If Applicable)- Choose One

Date Range of Records	**From**		**To:**	
☐	Hard Copy- Receiving Party Pickup	☐	E-Mail: I understand that transmission of my records in this format is not as secure as other methods and accept the risks involved	
☐	Hard Copy-Mail to Receiving Party			
☐	Fax / E-Fax			
☐	Other Method:			

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Client Name whose information will be disclosed	

I the undersigned, understand…

-I sign this authorization voluntarily and El Dorado County may not condition treatment, payment, enrollment or eligibility for benefits/services based on this authorization.

-I may revoke this authorization verbally or in writing-unless the disclosure has already been made or the disclosure is permitted or required by law.

Revocation of this authorization must be to the originating entity- Identity of revoker will be verified

Originating Entity Name: El Dorado County Behavioral Health Phone # (530)621-6290

Originating Entity Address: 768 Pleasant Valley Road, Diamond Springs, CA, 95619

-If my Protected Health Information includes alcohol and drug abuse information, I understand that the following statement applies: Federal laws and regulations protect the confidentiality of alcohol and drug abuse records maintained by a program.Generally, disclosure of any information identifying a client as an alcohol or drug abuser is prohibited unless: 1) the client consents in writing, 2) the disclosure is allowed by a court order, 3) the disclosure is made to health care personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation, or 4) the client commits or threatens to commit a crime either at the program or against any person who works for the program. Violation of the federal laws and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. (42 USC section 290dd-22 and CFR 42 Part2)

-Federal laws and regulations do not protect any information when child abuse or elder/dependent adult abuse is suspected by program staff. (CA Penal Code Sections11164-11174.3 and § 368-368.5, CA Welfare & Institutions Code § 15630)

-Re-disclosure of protected health information is prohibited without specific written consent from the person to whom the information pertains or as otherwise permitted by law.

-Information disclosed pursuant to this authorization may be disclosed by the recipient and no longer be protected by State of Federal Law.

-I have the right to receive a copy of this authorization and obtain a copy of the health information being disclosed including the entities the information was disclosed to.

This authorization for exchange of information to the named organization(s) shall become effective immediately and remain in effect for **ONE YEAR** from the date of signature, unless a different date is specified.	Enter date here if less than one year

Signature		**Self** ☐	**Parent/Legal Gaurdian** ☐
Printed Name		**Date:**	
Minor Consent (Ages 12-17) Signature		**Date:**	

Staff must sign below attesting that client identity was verified. Attach copy of state-issued identification for client if available

Staff Attestation Signature		**Date:**
Staff Attestation Printed Name		