



**El Dorado County Health & Human Services Agency
 Authorization to Use/Disclose Protected Health Information**

Person/Organization Authorized to EXCHANGE Information:

Name:

Address	City, State	Zip Code
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Phone: _____ **FAX:** _____

Person/Organization Authorized to EXCHANGE Information:

**El Dorado County Health & Human Services Agency, Behavioral Health Division
 768 Pleasant Valley Road
 Diamond Springs, CA 95619
 PHONE (530) 621-6290, FAX: (530) 303-1526**

Patient/Client Information:

Last Name	First Name	Birth Date
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Address	City, State	Zip Code	Phone
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Information to be Disclosed/Used: (Parent/Legal Guardian and Minor **initial all that apply)**

- | | |
|-----------------------------------|------------------------------|
| _____ Medical Information | _____ HIV/AIDS Information |
| _____ General Health Information | _____ Drug Abuse Information |
| _____ Mental Health Information | |
| _____ Other – specify here: _____ | |

The purpose of this authorization to use/disclose Protected Health Information:

[Check all that apply *and* explain]

- | | |
|--|---|
| <input type="checkbox"/> To coordinate care | <input type="checkbox"/> To coordinate treatment planning |
| <input type="checkbox"/> Requested by client | |

Explanation (required): _____

This authorization is valid for one year, or until _____
Date

I, the undersigned, understand:

- I sign this authorization voluntarily and El Dorado County may not condition treatment, payment, enrollment or eligibility for benefits or services based on this authorization.
- I may revoke this authorization in writing unless the disclosure has already been made or the disclosure is permitted or required by law.
- My revocation of this authorization must be in writing, signed by me or on my behalf and delivered to the following 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 Sections 11164-11174.3 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 or Federal Law.**
- **I have the right to receive a copy of this authorization.**

Signature: _____ Date: _____

Print Name: _____

Your relationship to the client: SELF Parent/Legal Guardian

Minor's Signature: _____ Date: _____

Print Minor's Name: _____