AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION
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Confidential Patient Information
See W&I Code Section 5328 and
HIPAA Privacy Rule CFR Section 164.508

INSTRUCTIONS: Use this form to obtain the required authorization when a request is received for patient information, unless the request received is a facsimile of this form or contains all of the required information. Obtain signature of patient or parent/guardian/ conservator. If patient signs, obtain "witness signature." List the information released per this authorization on the back of this form.

The hospital shall not condition treatment or payment based on this authorization. The patient may refuse to sign the authorization. If the authorization is not signed, the information shall not be released except when required by law. Upon request, the patient may inspect or be provided a copy of the protected health information to be disclosed by this authorization.

Patient's Name _____ Birth Date ___|___|___
Month Day Year

I, _____ and/or _____
Name of Patient Name of Parent/Guardian/Conservator

hereby authorize _____
Name of Agency/Person/Organization

_____
Address (Street, City, State and Zip Code)

to release to _____
Name of Agency/Person/Organization

_____
Address (Street, City, State and Zip Code)

the information specified on Page 2 of this form with the knowledge that such release discloses the fact that mental health services have been/are being provided.

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This disclosure of information* is required for the following purpose(s): **(initial applicable areas)** ☐ Evaluation ☐ Treatment Planning/Course ☐ Other (Specify) _____

and shall be limited to releasing the following types of information (initial all applicable areas): from (date required) _____to (date required) _____; or any information/records indicated, regardless of date.

☐ Entire Record
☐ Diagnosis
☐ Psychiatric Evaluation
☐ Discharge Summary
☐ Social History
☐ Individual Treatment Plan
☐ Legal Information
☐ Medical, Neurological Assessment, Lab Tests, e.g., EEG, EKG, etc.
☐ Seclusion and/Restraint Information
☐ HIV Tests Results
☐ Other Evaluations/ Assessments (specify)
_____
_____
_____
_____
_____
☐ Results of Psychological/ Vocational Testing
☐ Conference(s) Date(s)
_____
_____
_____
☐ Other (specify)
_____
_____
_____
_____

*The information disclosure under this authorization may be subject to re-disclosure by the recipient if allowed or required by law. This authorization becomes effective (Month/Day/Year) _____. This authorization may be revoked in writing by the undersigned at anytime except to the extent that action has already been taken. If not revoked, it shall terminate at the end of (check one): ☐ 6 months ☐ One year or ☐ Specify Date _____.

I understand that I am to receive a copy of this authorization.

_____ Date: ____|____|____
Signature of Patient Month Day Year

_____ Date: ____|____|____
Signature of Parent/Guardian/Conservator, if Applicable Month Day Year

_____ Date: ____|____|____
Witness Signature Month Day Year

_____ _____
Signature of Professional* Date Person Obtaining Authorization Date

*Professional for this authorization refers only to a Physician, Licensed Psychologist or Social Worker with a Master's degree in social work, or Marriage and Family Therapist who approves this patient initiated request for release of patient records.

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RECORD OF RELEASE OF INFORMATION

The following information was released to the named party specified on the front of this form. Identify the specific dates of the reports, records, items released.

- ☐ Entire Record
- ☐ Diagnosis
- ☐ Psychiatric Evaluation
- ☐ Discharge Summary
- ☐ Social History
- ☐ Individual Treatment Plan
- ☐ Legal Information
- ☐ Medical, Neurological Assessment, Lab Tests, e.g., EEG, EKG, etc.
- ☐ HIV Tests Results
- ☐ Results of Psychological/ Vocational Testing
- ☐ Other Evaluations/ Assessments (specify)
  _____
  _____
  _____
  _____
- ☐ Conference(s) Date(s)
  _____
  _____
  _____
- ☐ Other:

Released By (Name & Title) Date Released