AUTHORIZATION FOR THE RELEASE OF CLINICAL INFORMATION
(including Psychiatric/Drug-Alcohol Abuse)

Explanation: This authorization for use or disclosure of health information includes authorization for the release of information about behavioral and/or alcohol and drug abuse services and treatment and is being requested to comply with the terms of the Confidentiality of Medical Information Act of 1981, Section 56 et seq., California Civil Code, and the Health Insurance Portability and Accountability Act (HIPAA) 45 C.F.R 164.508 and the Lanterman-Petris-Short Act (Welfare and Institution Code Section 5000 et seq.)

Resident Name: _____ Birth Date: _____

Health Record No: Treatment Date(s):

Treatment Date(s): _____ Treatment Date(s): _____

Information to be released from: _____

Individual/Organization: _____

I Authorize the use and disclosure of the above named individual's health information as described below.

Most Recent D/C Summary	☐	Medication Records	☐
Nursing Notes	☐	Most Recent H & P Exam	☐
Care/Treatment Plans	☐	Physician's Orders	☐
Diagnoses	☐	Lab/X-ray Reports	☐
Consultation Reports	☐	Progress Notes	☐

Other (Specify) _____

Information to be Released to: _____

Individual/Organization: _____

Address: _____

Purpose: _____

This authorization is effective immediately will expire on the following date. _____
I understand that if I do not indicate an expiration date, it will expire in 6 months.

I understand that I have a right to revoke this authorization at any time. If I choose to revoke the authorization, I will submit the revocation in writing to the Health Information Department of the facility. I understand that the revocation will not apply to any information that has already been released in response to this authorization, and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

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I realize that this is a required consent and that I must voluntarily and knowingly sign this authorization before any records can be released, and that I may refuse to sign, but in that event the records cannot be released. If I do not sign this form, I understand that it will not affect my right to receive treatment or my continued eligibility for benefits. I understand that I have the right to inspect or copy the information to be used or disclosed.

I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Supervisor/Designee.

I further release my attending physician, consultants, the facility and employees from any liability arising from the release of information to the person(s)/agency designated above.

Disclosure [ ] will [ ] will not result in direct/indirect remuneration to the facility.

I understand that I have a right to receive a copy of this authorization upon my request.

_____ _____

Signature of Resident/Guardian/Representative Date

(Indicate by circling)

_____ _____

Signature of Witness Date

_____ _____

Signature of Physician (where applicable) Date

If signed by a person other than resident, add description of legal authority to act for the individual _____

A spouse or financially responsible party may only authorize release of medical information for use in processing an application for the resident, as a spouse or dependent, for a health insurance plan or policy, a nonprofit hospital plan, a health care service plan or an employee benefit plan.