

COUNTY OF PLACER AUTHORIZATION FOR RELEASE OF INFORMATION

Patient/Client Identifying Information				
LAST NAME:	FIRST NAME:		MIDDLE INITIAL:	
STREET ADDRESS:	CITY/STATE:		ZIP CODE:	
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:		CASE NUMBER:	
Person/Organization		Person/C	Organization	
Providing Information [45 C.F.R. § 164.508(c)(ii) & Civ. Code § 56.11(c)]		Receiving Information [45 C.F.R.§ 164.508(c)(iii) & Civ. Code § 56.11(f)]		
NAME:		NAME:		
STREET ADDRESS:		STREET ADDRESS:		
CITY/STATE/ZIP:		CITY/STATE: ZIP:		
PHONE: FAX:		PHONE:	FAX:	
Detailed Description of What Kind of Information To Be Released [45 C.F.R. § 164.508(c)(i)& Civ. Code § 56.11(d) & (g)]]				
☐ Entire Record		☐ Diagnosis (specify):		
☐ Medical Records Only			-	
☐ Mental Health Records Only				
☐ HIV/AIDS Test Results	•		☐ Evaluation/Assessment (specify, e.g.: bio-social, psychological, psychiatric):	
Social/Medical/Legal History				
☐ Treatment Attendance/Participation	1			
☐ Seclusion Restraint Information		☐ Test/Testing Results (specify, e.g.: X-rays, EKG, labs, psychological, urinalysis):		
☐ Individual Treatment Plan		rays, Elxo, iaos, psychological, urmalysis).		
☐ Immunization Records Only☐ Other:				
Relevant Dates, if known:				
I authorize this release to include information on services I have received for:				
☐ Mental Health ☐ Substance	Abus	e □ HIV/AIDS	☐ Genetic Testing	

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NAME: CASE NUMBER:

Detailed Description of How Information Will Be Used:				
(Examples: Evaluating; Monitoring Progress or Participation; Planning Treatment/ Case Management; Assessing Services; Patient/Client Request) [45 C.F.R. § 164.508(c)(iv)]				
This <i>Authorization</i> will expire on: (<i>date</i>) [45 C.F.R. 164.508(c)(v) & Civ. Code § 56.11(h)]				
I understand my rights:				
• I authorize the disclosure of my health information as described above for the purpose(s) listed. This <i>Authorization</i> is voluntary, as I understand my health information is subject to Federal and State privacy regulations. [45 CFR § 164.508(c)(2)(i)]				
• I have the right to revoke this <i>Authorization</i> in writing to the provider of this information listed above. The <i>Authorization</i> will stop on the date my request is received, except for action already taken, or if this <i>Authorization</i> was obtained as a condition of insurance, enrollment, or eligibility.[45 C.F.R. § 164.508(c)(2)(ii)& Civ. Code § 56.11(h)]				
• I understand the <i>Notice of Privacy Practices</i> provides instructions, should I choose to revoke my <i>Authorization</i> . [45 C.F.R. § 164.508(c)(ii)]				
• I understand that I am signing this <i>Authorization</i> voluntarily and that treatment, payment or eligibility for my benefits will not be affected if I do not sign this <i>Authorization</i> unless my treatment, enrollment in a health plan or eligibility for benefits are conditioned on me signing the <i>Authorization</i> . [45 C.F.R. § 164.508(c)(2)(ii)]				
• I understand if the organization I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by Federal privacy regulations. [45 C.F.R. § 164.508(c)(2)(iii)]				
• I understand I have the right to receive a copy of this <i>Authorization</i> .				
Signature of Patient/Client:	Date:			
Photocopy of this <i>Authorization</i> shall have the same mean	ing as the original.			
Signature of Parent, Guardian, Conservator, or Legal Representative (indicate relationship):	Date:			

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