Health Information Management

River Oak
Center for Children

5445 Laurel Hills Dr.
Sacramento, CA 95841
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AUTHORIZATION TO RELEASE & EXCHANGE PROTECTED HEALTH INFORMATION

_____ (DOB) _____ _____
(Print Name of Client) (Print Name of Parent, Guardian or Legal Representative)

I authorize River Oak Center for Children to receive, release, disclose and/or exchange information with: _____
Name of Agency/Person(s)

(____) _____ ☐ Unknown (____) _____ ☐ Unknown
Phone Number Fax Number

_____
Mailing Address of Agency or Person(s) ☐ Unknown

(Note: If contact information for the agency/person is not provided by the client/legal representative, River Oak may add the relevant contact information).

For what purpose is the information being disclosed?

☐ Continuing Treatment ☐ Coordination of Care
☐ Other: (please describe)_____

(Please check all that apply)

☐ **Verbal Exchange of Service Information**. The agency/person(s) listed above may verbally share information between themselves to coordinate services, care and treatment.

☐ **Document Exchange of Service Information**. The agency/person(s) listed above may exchange copies of records between themselves to coordinate services, care and treatment.

The types of health information that are to be released (Please check):

☐ Mental Health Diagnosis and Treatment ☐ Substance Abuse Diagnosis and Treatment ☐ HIV Information

Type of record(s) to be disclosed (Please check):

☐ Clinical Summary of Services	☐ Psychosocial Assessment
☐ Dates and Types of Services Received	☐ Discharge Summary
☐ Treatment Plan	☐ Psychiatric Evaluation
☐ Medication Authorization (JV 220)	☐ Prescription/Medication
☐ Diagnosis Only	☐ Laboratory Test Results
☐ Progress Notes	☐ Name, Address, Phone Number and Special Needs
☐ Other: _____	

Approved: 11/10; Revised: 11/11; 8/12; 4/15; 6/15; 6/17

Date range or date(s) of the records to be released:

From Date:_____ (month/day/year)	To Date:_____ (month/day/year)

By signing below, I indicate that:

- I authorize the use and disclosure of this information as described above.
- I understand that signing this authorization is voluntary, and that my refusal to sign will not affect my ability to obtain treatment, enrollment, payment or eligibility for services.
- I understand I have a right to revoke this authorization at any time. The request must be made in writing and submitted to the attention of the Privacy Officer at River Oak Center for Children; 5445 Laurel Hills Dr. Sacramento, CA 95841. The revocation will be effective upon receipt, but will have no impact on uses and/or disclosures made while this authorization was valid.
- I understand that the information being disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure in some cases is not protected by California law and may no longer be protected by Federal confidentiality law (HIPAA). If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R. Part 2.
- I understand that there may be fees incurred for this request.
- I understand that I have a right to receive a copy of this authorization**.**

Authorization Expiration: Unless revoked, this authorization expires on _____ (insert date). If no date is indicated, the authorization will expire 12 months after the date of my signing this form.

_____ _____

Signature of Client (age 12 and older required) **Date**

_____ _____

Signature of Parent, Guardian or Client Representative **Date**

_____

Relationship to Client

_____ _____

Witness - Staff Printed Name and Signature **Date**

Note: Any Attempt To Falsely Gain Access To Protected Health Information Is Subject to Legal Penalties. All Requests Have a 30 Day Time Frame For Processing.

Approved: 11/10; Revised: 11/11; 8/12; 4/15; 6/15