**AUTHORIZATION TO RELEASE & EXCHANGE PROTECTED HEALTH INFORMATION**

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| --- | --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| (Print Client Name) | (Print Preferred Name) | ( DOB) |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| (Print Name of Parent, Guardian or Legal Representative) | | |

I authorize River Oak Center for Children to receive information from, release information to,

exchange information with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Agency/Person(s)

(\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number  Unknown Fax Number  Unknown

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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).

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| **For what purpose is the information being disclosed?** | | | | | |
| Continuing Treatment | Coordination of Care | | Other (describe):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **How Can Information be Exchanged? (check all that apply):** | | | | | | |
| **Verbal Exchange** The agency/person(s) listed above may verbally share information between themselves to coordinate services, care and treatment. | | | | | | |
| **Document Exchange, of Service Information**. Please specify date range and select records below. From Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (month/day/year) (month/day/year) | | | | | | |
| **Type of record(s) to be disclosed (check all that apply):** | | | | | | |
| Clinical Summary of Services | | Psychosocial/ Life Domain Assessment | | | | |
| Dates and Types of Services Received | | Discharge Summary | | | | |
| Treatment Plans/ Care Plans | | Psychiatric Evaluation | | | | |
| Medication Authorization ( JV 220) | | Prescription/Medication | | | | |
| Diagnosis Only | | Laboratory Test Results | | | | |
| Progress Notes | | Name, Address, Phone Number, Special Needs | | | | |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  | | | | |
| **The types of health information that are to be released (check all that apply):** | | | | | | |
| Mental Health Diagnosis and Treatment | Substance Abuse Diagnosis and Treatment | | | HIV Information | Sexual Orientation, Gender Identity or Expression | |

**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.**

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| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **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** |