



**County of Sacramento
AUTHORIZATION TO OBTAIN
OR RELEASE PROTECTED
HEALTH INFORMATION (PHI)**

CONTACT:

Client Name (First, Middle, Last): *Print Neatly*	
Date of Birth:	Record #:
Address:	
City/State/Zip Code:	
Phone #: ()	
Email (Optional-For Contact only)	

OBTAIN from (Individual or Entity that has the Protected Health Information):

RELEASE (disclose) your Protected Health Information to:
Recipient Name:
Address:
City/State/Zip Code:
Phone #: () **Fax #: ()**

PURPOSE: The health information disclosed may only be used for the following purpose(s):

INFORMATION TO BE RELEASED:

<input type="checkbox"/> All Medical Records (<u>Except Mental Health, Alcohol/Drug or HIV unless indicated in next section</u>)	<input type="checkbox"/> Attendance Only Records
<input type="checkbox"/> Lab Tests	<input type="checkbox"/> Consultation Reports/Physician Order
<input type="checkbox"/> Medication	<input type="checkbox"/> Progress Reports/Notes
<input type="checkbox"/> Treatment/Personal Service Plan	<input type="checkbox"/> Psychiatric/Psychological Assessment/Testing Results
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Billing or Payment Information
<input type="checkbox"/> Social History	
<input type="checkbox"/> Records from a specific visit or hospitalization (Enter date and location):	
<input type="checkbox"/> Other (Must describe):	

NOTE: Records relating to mental health, or alcohol/drug departments, or results of HIV antibody tests are specifically protected, and will not be disclosed unless you sign below:

<input type="checkbox"/> Mental Health records	Signature:
<input type="checkbox"/> Alcohol/Drug dependency treatment records	Signature:
<input type="checkbox"/> HIV antibody test results	Signature:

EXPIRATION: This Authorization will expire on ____ / ____ / ____ date. (mm/dd/yyyy) (Must be no more than one year from the date of signature.)

REVOCAION: You or your personal representative can revoke this authorization at any time upon written request. Revocation will take effect upon receipt, except to the extent that others have acted upon this authorization prior to receipt of the revocation.

REDISCLASURE: Re-disclosure of these records is not allowed unless another authorization is obtained from you, or such disclosure is specifically required or permitted by federal or state law.

I understand that I have a right to a signed copy of this authorization.

Client's Signature	Printed Name	Date
Personal Representative's Signature	Printed Name	Date

STAFF PERSON WHO VERIFIED IDENTITY OF THE ABOVE (Print Name):

VERIFICATION: We are required to verify you have the authority to sign this form. You will need to provide picture identification, like a California state ID or a California driver's license. (See County HIPAA Privacy Rule Policy and Procedures for other acceptable forms of identification). You are required to attach a copy of the picture identification or present it in person.

VERIFICATION for Personal Representative: If the signer is a guardian or legal custodian of an adult, minor, emancipated minor or a representative of a deceased client and is authorized by state law to act on behalf of the individual in making decisions about health care, a copy of the legal authority (guardianship or custody order) must be attached to this form. If the signer is a personal representative that does not have the legal authority, the patient must provide documentation in writing appointing this person as a representative and this documentation must be attached.

General Medical Records: Re-disclosure of these records is not allowed unless another authorization is obtained from you, or unless such disclosure is specifically required or permitted by federal or state law.

HIV, Alcohol and Drug, and Mental Health Treatment: These records are protected under federal or state law and cannot be disclosed without your written authorization unless otherwise provided. All HIV test information released must be labeled with a statement that: "This information may not be disclosed to any one without the specific written authorization of the individual."

This authorization is voluntary. The client's health information may be protected under federal or state confidentiality laws. These federal or state laws may not apply to the person or organization receiving the information being shared. The client may choose not to sign this authorization and this will not affect their ability to obtain treatment or payment or my current eligibility for health care benefits. However, if this information is necessary to determine if client is eligible to enroll in the Sacramento County Health program, the client may not be able to show they qualify for these services.

(If applicable) Client understands that County of Sacramento has been asked to provide a health care service (such as a test or evaluation) only for the purpose of being able to provide that information to someone else, and if client chooses not to authorize the disclosure of that information to the other person, then County of Sacramento may not provide that health care service to the client.

VALID AUTHORIZATION: THIS AUTHORIZATION IS NOT VALID IF:

The authorization is missing the elements described below:

- A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.
- The name or other specific identification of the person authorized to make the requested use or disclosure.
- The name or other specific identification of the person(s) or class of persons to whom the covered entity may make the requested use or disclosure.
- A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
- A specific expiration date not to exceed one year from the client's signature.
- Signature of the client or client's personal representative and date.