



Confidential Patient Information:
 See California Welfare and
 Institutions Code Section 5328

Authorization for Use or Disclosure of Protected Health Information

Completion of this document authorizes the disclosure and/or use of individually identifiable health information as set forth below, consistent with California and Federal law concerning the privacy of such information. **Failure to provide *all* information requested may invalidate this Authorization.**

Client Name _____ DOB _____
 BHRS # _____

I authorize the exchange of health information (as specified below) between San Mateo County Behavioral Health and Recovery Services **AND** the following person/organization:

Name/Agency _____

This Authorization applies to the following information (Select one or more of the following):

- Assessment including diagnosis
- Treatment Plan
- Discharge Summary
- Entire health record with history of mental and physical condition and treatment provided, including drug/alcohol and/or HIV/AIDS
- Only the following health information _____
- Only information from _____ to _____
 (Date) (Date)

This information will be used for the following purpose(s):

- Assessment/Treatment
- Consultation/2nd opinion
- Other (Specify) _____

Unless consent is revoked, this Authorization shall be valid until the specific date stated below or upon discharge from San Mateo County Behavioral Health and Recovery Services, whichever occurs first:

- 3 years from the date this form is signed/authorized. Date of expiration: _____
- Other Date: _____ (If other than the date specified above)



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RESTRICTIONS

California law prohibits the requestor from making further disclosure of my protected health information unless the Requestor obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

MY RIGHTS

I may refuse to sign this Authorization. I may inspect or obtain a copy of the protected health information that I am being asked to disclose. I have a right to receive a copy of this Authorization. I may revoke this Authorization at any time. My revocation must be in writing and sent to my primary clinic/clinical team.

My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this Authorization.

Treatment, payment, enrollment and/or eligibility for benefits will not be based on my providing, or refusing to provide, this Authorization.

Send my health information to:

Name _____
 Fax _____ Tel _____
 Address _____
 Email Address: _____

Client/Legal Representative

Signature/Name _____ **Date** _____
 Client/Legal Representative

If signed by someone other than the client, legal relationship to the client is: _____

Witness/Clinician Signature _____ **Date** _____

(California law prohibits recipients of your health information from re-disclosing such information except with your written authorization or as specifically required or permitted by law. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected.)