



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

**Authorization for the Verbal Release of Protected Health Information to Family,
 Friends, or Individuals Providing Social Support**

Name of Client _____

Date of Birth _____ Mental Health # _____

I hereby authorize SAN MATEO COUNTY MENTAL HEALTH SERVICES DIVISION to **verbally** discuss the following information obtained in the course of my psychiatric and/or drug and alcohol assessment and treatment, as indicated by my initials, to designated person(s):

_____ My general status in the program _____ My general physical/mental health
 _____ My medication _____ Treatment related information _____ Hospitalization
 _____ Other: _____

The above indicated information may be **verbally discussed** with the following:

Name _____	Name _____
Phone _____	Phone _____
Relationship _____	Relationship _____

This consent is limited to the release of **verbal** information only. Release of the specified **verbal** information to any person not specified is prohibited. This authorization shall be valid until 3 years from the date this form was signed/authorized, unless consent is withdrawn in writing, or another date is specified. **Date of expiration** _____

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 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 rediscovered and may no longer be protected.)