San Mateo County Behavioral Health and Recovery Services

Authorization for Use or Disclosure of Protected Health Information

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

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

Clinic/Unit _____ Address _____

AND the following person/organization

Name _____ Address _____

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) _____

Client Name _____

Unless consent is withdrawn in writing, this Authorization shall be valid for one year from the date signed, or until _____.
(Specify date sooner than one year.)

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, signed by me or on my behalf, and delivered to the following address _____
_____

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 _____

Signature _____ **Date** _____
Client/Legal Representative
If signed by someone other than the client, legal relationship to the client is _____.

Witness/Clinician of Client/Representative Signature _____

(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.)

Make copy of completed Authorization and give to client.