



County of San Luis Obispo Behavioral Health
Release of Information

Client Name _____ Date of Birth _____ Client ID _____

AUTHORIZATION TO OBTAIN/DISCLOSE PROTECTED HEALTH INFORMATION

General

Authorization for the Disclosure of Protected Health Information

By signing this form below, I am authorizing the disclosure of my protected health information to one or more persons for the purposes specified on this form. If I agree, I understand this may include information about any substance use disorder treatment I have received.

Release To/Obtain From

Name or other specific identification of person(s) authorized to receive/make the requested use or disclosure.

Organization/Provider Contact Release To Obtain From

Release To/Obtain From: _____

Purpose of Disclosure

Process insurance/third part claims Treatment/Care Coordination
 Quality Improvement Other _____

Preferred Method of Delivery

Paper Encrypted Email Unencrypted Email
 Fax Encrypted USB In-Person Drop-Off/Pick-Up
 Other: _____



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Expiration

If nothing is marked, the authorization will expire one (1) year from date signed. If you would like to specify a different expiration date, then do so by selecting one of the alternative options below or using the "end date" box below.

1 time disclosure 6 months

Start Date _____ **End Date** _____

Information to be used or disclosed

The information that can be disclosed under this authorization includes the following, if available

Type: MH SUD

- All Records Acknowledgement of Treatment Medications Prescribed
- Billing &/OR Insurance Information Intake/Admission Information
- Psychological Evaluation(s) Reports Discharge Summary/Plan
- Progress Review /Summary Screening Assessment(s)
- School Records/Reports/IEPs Treatment Plan(s) Progress Notes
- Medical History, Lab Results, Immunization Records
- Other _____

Records Start Date _____ Records End Date _____



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Restrictions

Terms

I understand:

- Under state and federal confidentiality provisions only the information specified can be released.
- The recipient(s) of my information may disclose it to others. I understand that in some cases my information may no longer be subject to privacy laws once it is disclosed.
- I may revoke this authorization at any time, but a revocation will not apply to information that has previously been released.
- If not otherwise specified, this authorization will expire in one (1) year from the date of signature.
- This authorization is voluntary, and that declining to sign this authorization will not impact my ability to get medical care, health insurance, or any government benefits. I have been given the chance to ask questions and receive answers pertaining to this document.
- I have a right to a copy of this form.

Signing for a Child

- I understand that if I am signing this form on behalf of a minor, I should include my name as the "Legal Representative" of my child, and that I should sign this form. If my child is 12 or older, my child should also sign.

By signing, I authorize the disclosure as described above.



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Agency Contact Information

Program _____ Attention _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Copy Given to Client Yes Declined a copy

Agency Staff _____

ID verified by: Driver's license Other picture ID Known to Agency

Information about HIV/AIDs and Substance Abuse Treatment -

Information about HIV/AIDs status and treatment for Substance Abuse will not be released without your specific permission. Do you authorize these releases of information to the person/organization listed above?

Alcohol/Drug Abuse:

I authorize the release of information relating to referral and/or treatment for alcohol and drug abuse.

I **PROHIBIT** the release of information relating to referral and/or treatment for alcohol and drug abuse.

HIV/AIDS/Sexually Transmitted Disease/Communicable Disease

I authorize the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.

I **PROHIBIT** the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.



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Client Name _____ Date of Birth _____ Client ID _____

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Relationship _____

Staff Signature _____ Date _____