Solano County Health & Social Services Department

Mental Health Services
Public Health Services
Substance Abuse Services
Older & Disabled Adult Services

Eligibility Services
Employment Services
Children's Services
Administrative Services

Gerald Huber, Director

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

By completing this document, you authorize the disclosure and/or use of your protected health information (PHI). Unless otherwise indicated, all sections of this form must be completed in order to be valid

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:

Date of Birth:	SS# (optional):	Telephone Number:
Medical Record # (if known):		

Who is authorized to release your records? Name and Address	**Who do you want to receive your records?** Name and Address
	Fax:

Description of information to be released
Please *initial* each box that applies

☐ Complete Physical/Medical Record (excluding protected class information)	☐ Pharmacy Records	☐ Progress Notes
☐ History and Physical Exam	☐ X-Ray Reports	☐ Billing Records
☐ Laboratory Test Results	☐ Immunization Records	☐ Dental Records
☐ Consultation Reports	☐ Other (Specify)	☐ Other (Specify)

Protected Class Information

Special approval, as required by law, is needed before the protected classes of information can be released. These types of information may or may not be contained in your medical records. The following information ***will not*** be released, to the extent any record(s) exist, unless you specifically authorize it by ***initialing the space below***:

Drug and Alcohol Records

_____ Assessment, diagnosis, and prognosis
_____ Urine Test
_____ Progress in Treatment
_____ Date of Attendance
_____ Complete Drug and Alcohol Records

_____ HIV Antibody Test Results

Mental health Records

_____ Assessment and diagnosis
_____ Consultations
_____ Psychological Testing
_____ Progress Notes
_____ Psychiatric Evaluation
_____ Complete Mental Health Records

Dates/Time Period of Records to Be Released

The records covered by this release include only the records created during the period from (date) _____ to (date) _____. If dates are not specified, this authorization will include the release of all records checked or initialed.

Purpose of Disclosure

☐ Treatment or consultation	☐ Patient Request	☐ Other (Specify)

RIGHT TO CANCEL: I understand that:
I have the right to cancel this authorization at any time by sending a notice canceling this authorization to the provider(s) listed on page 1 of this form. Cancellation of this authorization will not apply to information that has already been released based on this authorization.

EXPIRATION: Unless otherwise cancelled, this authorization will expire on:
☐ Completion of this request (one time disclosure). ☐ One Year from signature date ☐ The specified date: _____ The authorization will be voided on the date of cancellation or expiration, except if action has been taken in reliance on it.

RE-DISCLOSURE: I understand that:
Client records disclosed because of this release may be re-disclosed and no longer protected by Federal confidentiality regulations (HIPAA). However, California state law prohibits recipients of these records from re-disclosing this information except with your written authorization or as required by or permitted by law. Client records released by Solano County Drug and Alcohol Division are further protected by both state and other federal confidentiality regulations.

OTHER RIGHTS: I understand that:

- Authorizing the disclosure of my records is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or to create health information to provide to a third party. Under no circumstances am I required to authorize the release of mental health records.
- I may inspect or obtain a copy of the information to be used or disclosed.
- I have a right to request a copy of this authorization.
- Fees may be charged for copy services.
- I have authorized the use or disclosure of my individually identifiable health information as described above for the purpose(s) listed.

Signatures

Client Signature: _____ Date: _____

Authorized Representative Signature: _____ Date: _____

Relationship: ☐ Parent ☐ Guardian ☐ Conservator

☐ Other (Specify) _____

Approval to Disclose (to be completed by Custodian of Records):

☐ Yes ☐ No. If no, state reason_____

Clinician Approval, if applicable[1]: _____

[1] Under certain circumstances, the approval of a physician, licensed psychologist, social worker with a master's degree in social work, or licensed marriage and family therapist, who is in charge of the patient may be required before records may be released.