EMQ FamiliesFirst

Headquarters: 251 Llewellyn Avenue, Campbell, CA 95008
Phone (408) 379-3790 Fax (408) 364-4013 www.emqff.org

EMQ FF staff only

REQUEST TO RELEASE HEALTH INFORMATION

(Please see reverse side of form for information regarding your rights)

Youth / Client Name_____ DOB_____/_____/_____

I,_____ and/or _____
(Name of Client/Youth, if age 12 or over) (Name of Parent / Legal Guardian)

authorize care providers at **EMQ FamiliesFirst** to receive, release / disclose and/or exchange information with:

_____ (____) _____ (____)_____
Name of Agency / Party Phone Number Fax Number

_____
Mailing Address of Agency / Party

the following information:

A. ❑ All health information regarding services and treatment received **OR**
❑ Only the following records or types of health information (including any dates)

_____

B. I specifically authorize release of the following information (check as appropriate):

❑ Mental Health Treatment Information
❑ Substance Abuse Information

For the purpose of:_____
(Records cannot be released without a purpose listed)

This authorization will expire on [insert date]_____. If no date is listed, this authorization will be valid one year from signature date or until discharge (whichever comes first).

_____ _____/_____/_____
Signature of Client/Youth, if age 12 or over Date

_____ _____/_____/_____
Signature of Parent//Legal Guardian Relationship to Youth/Client Date

***Parent must have legal custody. Legal guardians/conservators must show proof of status**

Mail completed form to the address provide above or fax to (408) 364-7065
Attention Health Information Management

EMQ FF staff only: Date completed form received:_____/_____/_____ Received by:_____

Request to Release and Exchange - Website
FORM # 569 Eng
Revised 09/04/09

EMQ FamiliesFirst

Headquarters: 251 Llewellyn Avenue, Campbell, CA 95008
Phone (408) 379-3790 Fax (408) 364-4013 www.emqff.org

Authorization To Release & Exchange Confidential Information

(Please see reverse side of form for agency authorization information)

Your Rights:

You may refuse to sign this Authorization. Your refusal will not affect your ability to obtain services at EMQ FamiliesFirst.

You may revoke this authorization at any time by notifying EMQ FamiliesFirst in writing. Your revocation will take effect upon receipt except to the extent that others have acted in reliance upon this authorization. A request for revocation should be mailed to:

EMQ FamiliesFirst
Attn: Privacy Officer
251 Llewellyn Avenue
Campbell, CA 95008

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

You have the right to receive a copy of this authorization.