Sierra County Health & Human Services

AUTHORIZATION FOR RELEASE OF INFORMATION

A photocopy/facsimile copy may be used as an original

Your Information

Last Name: First Name: Middle Initial:

Street Address: P.O. Box: City/State: Zip:

Person/Organization Providing Information:

Sierra County Behavioral Health
704 Mill Street | P.O. Box 265
Loyalton, CA 96118
PH: (530) 993-6746 FAX: (530) 993-6759

Person/Organization Receiving Information:

Name: _____
Position or Role: _____
Address: _____
City/State/Zip: _____
Phone # : _____ Fax # : _____

Description of Information to be Released

(Provide a detailed description of the specific information to be released.)

[*45 C.F.R. § 164.503(c)(1)(i)* | CA *Civil Code § 56.11(d), and (g)*]

Check each type of confidential information you authorize to be released:

☐ HIV or AIDS Information
☐ Alcohol/Drug Information
☐ Mental Health / Behavioral Health Information
☐ Genetic Testing
☐ Other: _____

For the following period of time: from _____ (date) to _____ (date).

Description of the Purpose and Limitations for the Use or Release of the Information

(Indicate how information will be used.)

[*45 C.F.R. § 164.508(c)(1)(iv)* | CA *Civil Code § 56.11(g)*]

___The information will not be used for any purpose other than its intended use. ___

Will the health plan or provider receive money for the release of this information?

[*45 C.F.R. § 164.524(c)(4)*] ☐ Yes ☐ No

* * * Reasonable fees may be charged to cover the costs of copying and postage.* * *

This authorization for release of the above information to the above named persons or organizations will expire on: _____(date).

I understand that:

- I authorize the use and/or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary.
- I have the right to revoke this authorization at any time by sending a signed notice stopping this authorization to **Sierra County Behavioral Health at 704 Mill Street | P.O. Box 704; Loyalton CA 96118**. The authorization will cease on the date my valid revocation request is received.
- The notice of Privacy Practices provides instructions for me should I choose to revoke my authorization and includes limitations on my revocation.
- My treatment, payment, enrollment, or eligibility for benefits will not be affected if I do not sign this authorization.
- Under California law, the recipient of my medical information is prohibited from re-disclosing the information, except with a written authorization or as specifically required or permitted by law.
- If the organization or person I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I have the right to receive a copy of this authorization.

Records and copies obtained relating to outpatient psychotherapy care shall be returned or destroyed at the expiration date of this authorization except those obtained for treatment and diagnosis purposes.

_____

Patient Signature**:** Date**:**

_____

_____

Patient's (Personal) Representative Signature**:** Relationship**:** Date**:**

_____