Sierra County Health & Human Services
Consent for the Release of Information

A photocopy/facsimile copy may be used as an original

Client Information		
Last Name:	First Name:	Middle Initial:
Address:	City/State/Zip Code:	Date of Birth:
Phone Number:	Client Case Number:	

I, ____, authorize
(Name of Client)

_____ Sierra County Public Health
_____ Sierra County Mental Health
_____ Sierra County Social Services
_____ Sierra County Substance Use Disorder

(Name or general designation of program making disclosure)

Authorization Details

I authorize the following individuals and entities to use, disclose and exchange Protected Health Information (as specified in this form) about me:

_____ Sierra County Substance Use Disorder
_____ Sierra County Social Services (CPS/APS)
_____ Sierra County Social Services (Eligibility)
_____ Sierra County Mental Health
_____ Sierra County Public Health
_____ Sierra County Office of Education
_____ Other_________________________
_____ Sierra County Superior Court
_____ Sierra County Probation Dept.
_____ Family Resource Center
_____ EPHC Loyalton/Portola Campus
_____ WSMC - Downieville
_____ Loyalton Pharmacy
_____ Other _______________________

Purpose Of Disclosure Of Protected Health Information (PHI)

_____ Patient request; or
_____ Be Specific: ____
____
____

Service Dates

The information to be used or disclosed includes only those items checked below, with respect to services provided on or around:____________________ (insert dates of service). NOTE: If this section is left blank, the treatment dates covered by this authorization will be limited to the records associated with the last visit or course of treatment.

Expiration of Authorization

THIS AUTHORIZATION SHALL BECOME VALID IMMEDIATELY AND SHALL REMAIN IN EFFECT FOR THE FOLLOWING PERIOD: (The Client/Patient) MUST INITIAL one of the following for the authorization to become valid.)

_____ This authorization expires one year from the signature date below.

_____ This authorization expires as specified:_________________________

_____ This authorization expires once PHI is disclosed. This is a one-time authorization.

Type Of Protected Health Information To Be Used Or Disclosed

I understand that this authorization extends to all or any part of the records/information designated below, which may include information related to mental health and substance use disorder services, and HIV or AIDS. The information to be used or disclosed includes: **(The client MUST INITIAL items being requested).**

_____ **Physical Health**

_____ **Mental Health**

_____ **Substance Use Disorder**

_____ **HIV/AIDS**

_____ Discharge Summary

_____ Psychiatric Evaluation

_____ Medication Records

_____ Inpatient Records

_____ Progress Notes

_____ Substance Use Disorder Records

_____ Attendance Only

_____ Lab Reports

_____ Intake/Admission Summary

_____ Medical Finding

_____ Billing Records

_____ Other (Please specify)____

This authorization is limited to only that information that I have requested above to be used or disclosed to the persons/facilities named herein.

Client Rights & Resposibilites

1. Redisclosure under HIPAA: Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
2. Revocation: I have the right to make a written request to stop the use or disclosure of information at any time and submit it to the following address:

_____ Sierra County Behavioral Health, PO Box 265, Loyalton, CA 96118

_____ Sierra County Public Health, PO Box 7, Loyalton, CA 96118

_____ Sierra County Social Services, PO Box 1019, Loyalton, CA 96118

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

3. Refusal to sign: I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits except as may be permitted by law.
4. Copy: I understand that I will receive a copy of this authorization upon my request. However, for requests for other file copies, a fee may apply.

Acknowledgement

Client Signature: ____ Todays Date: ______________

If Applicable:

Parent/Guardian/Authorized Representative Signature: ________________________________

Todays Date: __________________________________

Print Name: _____________________________________Telephone Number:_________________

Complete Address: ____

Relationship to Client: ____

Staff Verification

_____ I have verified the client's signature against the medical record.

_____ I have received ____________________________ as documentation that verifies the relationship with the client and the authority to request/receive health information on behalf of the client.

Staff signature____ Date: _______________

Print staff name:____

COPY ( ) Delivered on:_________________________ ( ) Faxed On ________________________

( ) Mailed on ____________ ( ) Retained in File Only ( ) Given to Client on ________________