SISKIYOU COUNTY BEHAVIORAL HEALTH SERVICES AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION-RELEASE OF INFORMATION

Section I: Client Information (Completed by Client)	
This authorization is in regard to:	
DOB:	Client Number:

Section II: <u>Please Return ROI to</u>: Siskiyou County Behavioral Health Services, 2060 Campus Drive, Yreka, CA 96097 Tel: 530-841-4798 Fax 530-841-4799

Section III: Purpose of Disclosure of Confidential and/or Protected Health Information (PHI)
Purpose:

Section IV: Expiration of Authorization (Completed by Client – Applicant or Recipient of Services)	Initial
This authorization expires one year from the signature date in Section IX, or	
Other:	

Section V: Type of documents to be released Initial by each type of document that you wish to be released. (Completed by Client – Applicant or Recipient of Services)	Initial
Treatment plan including supporting documentation.	
Mental health assessments, diagnosis, treatment, progress notes and supporting documentation.	
Psychiatric assessment, medical documentation, including prescribed medications.	
Educational records including test results, grades and special service records.	
Court records including, but not limited to, Juvenile and Drug Court.	
Substance abuse history, substance abuse results, treatment plan and progress notes.	
Other:	

Section VI: Authorization Definitions (Reviewed by Client – Applicant or Recipient of Services)
Exchange (Ex) means the giving and receiving back and forth of information between parties. By marking exchange it can be understood that the client has authorized that each of the agencies marked are intended to both give and receive information.
Disclose (Disc) means to give or release information without getting any information back. For example a client may wish to have their records disclosed to their private doctor, attorney, or another County department.
Request (Req) means getting information from a party without giving any information to them. The client would like the agency to request their records/information from another provider, another County, etc. and not give any information in return.

	Section VII: Agency Authorized to Disclose, Exchange or Request Confidential and/or Protected Health Information (PHI) - initial to **left** of agency and check type of authorization**. Do not write in shaded area when first completing this form.** That section is for changes at a later date.						
Initial	**Agency or Individual**	**Date Range or All**	**Ex**	**Disc**	**Req**	**Initial**	**Date**

To make a change to an existing agency/program: Line through, initial and date the change at the **right**. If adding a new request, check the appropriate box, initial and date the addition at the **right**.

Section VIII: Client Rights and Responsibilities (Reviewed by Client – Applicant or Recipient of Services)
Note to Client: You have a right to receive a completed copy of this form upon request free of charge.
1. Person releasing and/or receiving information pursuant to this authorization may not release information to any person or entity not authorized by this release to receive information (Civil Code Section 56.13).
2. The parent, guardian, or conservator has the right to receive a copy of this authorization (Civil Code Section 56.11). A duplicate of the original is as effective as the original.
3. This authorization shall remain in effect for one (1) year following the date of signature unless revoked earlier in writing. I may revoke this consent by submitting a written request at any time, except as to information already exchanged in reliance upon my consent, as per Siskiyou County's Notice of Privacy Practices.
4. I understand that information used or disclosed in accordance with this authorization may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). However, federal and state regulations governing confidentiality still apply.
5. My refusal to sign this authorization will NOT affect my ability to obtain treatment, payment, enrollment or eligibility for benefits.

Section IX: ***I understand in signing this authorization that I am allowing release of the information identified above. I also understand that any disclosure made regarding alcohol and/or drug abuse treatment is bound by California Health & Safety Code § 11977 and 42 CFR Part 2 of the Federal Regulations.***
Signature of Client, Parent or Guardian: Date:
Printed Name of Client, Parent or Guardian:
Relationship to Client:
Witness: Date:

Section X: Staff Verification - Internal Use only I have verified the client's identity by:
☐ Government issued photo ID (driver's license, military id, etc.)
☐ Compared the signature against the client's signature in the chart/medical record/etc.
☐ Personal knowledge of the client