Calaveras Health and Human Services Agency

891 Mountain Ranch Road, San Andreas, CA 95249

Mental Health Program 209-754-6525 **Substance Abuse Program: 209-754-6555**
Fax: 209-754-6534 **Fax: 209-754-6559**

AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Client's Full Name DOB

A. I hereby authorize information to be released between:

Calaveras County Behavioral Health and:

Name (school): _____

Address_____

Phone Number _____ Fax # _____

Any and all records that I have initialed below:

1.____Progress notes, assessment, diagnosis and prognosis
2.____Treatment history, plan and details of participation
3.____Periodic reports to evaluate patient progress in treatment
4. ___ Results of psychological tests
5.____ Results of medical services
6.____ Drug Testing
7.____ Verbal exchange as needed, IEPs, discipline records, pertinent records
8. ___ Communication of crisis evaluation outcome and recommendations for follow-up.

B. For the time period: _____ to _____ (1 year from date of signature).

C. The release of this information is for the purpose of:

1. ___For treatment coordination and collaboration
2. ___Satisfying legal requirements
3. ___Client request
4. ___ For collaboration and planning around the outcome of a crisis evaluation.

D. I understand that I may revoke or cancel this release at any time, except to the extent that CCBHS or others have relied upon it. The revocation can be made at any time by telephone, orally in person, or in writing to CCBHS at 891 Mountain Ranch Road, Dept 127, San Andreas, Ca, 95249. Phone number: 209-754-6525. This revocation will take effect upon receipt.

E. When do you want this release to expire? This release is good for one (1) year from the date that it is signed, unless an earlier expiration date is written here:

_____

F. Your Rights

- I understand that I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment, payment or eligibility for benefits.
- I understand that I have a right to receive a copy of this authorization upon request.
- I understand that I have a right to inspect or receive a copy of the confidential information that I am being asked to authorize the disclosure of.
- I understand that information disclosed pursuant to this authorization could be re-disclosed by the recipient unless protected by California or federal law.

G. Signature

I have read this authorization carefully and have had all my questions answered

Your signature: _____

Signature Date: _____

Printed Name: _____

Relationship to client: _____
(Self, Parent, Guardian, Conservator)

Note: Minors 12 years of age and older must sign the authorization along with their parent/guardian.

For Recipients of Information: Information that has been disclosed to you may contain records which are protected by federal confidentiality rules (42 C.F.R. Part 2) This law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.