Authorization to Exchange Protected Health Information

AUTHORIZATION: I give permission to:

Name of Agency, Individual, or Health Care Provider:		
Address:	City/State:	Zip Code:
Telephone Number:	Fax Number:	Contact Name (if known):

To exchange information with the:

Division of Community Mental Health Services – County of Marin		
Department of Health and Human Services	Telephone:	(415) 499-6835
250 Bon Air Road, Greenbrae, CA 94904	Fax:	(415) 507-4113
Contact: Custodian of Medical Records		

The information, as identified below, relates to the following client:

Name (*print first name, middle initial and last name*):	Date of Birth (*month/day/year*):

INFORMATION: The following information is requested:
Important: Check the appropriate box or boxes and initial or sign and date as required.

☐ Records relating to _____
☐ Records [Date(s)]: From _____ To _____

☐ Attendance Only Records
☐ Billing or Payment Information/Records
☐ Consultation Reports
☐ Diagnosis
☐ Discharge Summary
☐ Medication(s)
☐ Medical, Neurological Assessment or Lab Tests (*EEG, EKG, etc.*)
☐ Progress Reports
☐ Psychiatric/Psychological Assessment
☐ Treatment or Personal Service Plan
☐ X-Rays

** Medical records may include information related to alcohol/drug or mental health treatment or diagnosis and/or results of an HIV or STD test. However, if you do not check the box(es) below, the information will not be released with your entire medical record. If you check any of the boxes below, additional legal requirements regarding the information may apply before release can be made.*

☐ Entire Medical Record _____ (Initials Required)
Client authorizes the release of the following information:
- ☐ Alcohol/Drug Treatment _____(Signature/Date Required)
- ☐ Mental Health Treatment _____(Signature/Date Required)
- ☐ Results of an HIV Test _____ (Signature/Date Required)
- ☐ Results of an STD Test _____ (Signature/Date Required)

☐ Notify Family in Case of Emergency
☐ *Verbal Communication Only*

Client Name (print first name, middle initial, last name):	Date of Birth (*month/day/year*):

PURPOSE: The information may be used only for the following reason(s):

☐ For Continuity of Care
☐ For Treatment Planning/Case Management
☐ Other _____
☐ To provide medical services
☐ At the request of the client

RE-USE OF INFORMATION: I understand that if I authorize the release of my health information to someone who is not legally required to keep it confidential, that information may be shared with others and may no longer be protected. I also understand that under no circumstances am I required to authorize the release of psychotherapy notes.

CONDITIONS: I understand that I do not have to sign this Authorization form. I understand that treatment, payment, enrollment and eligibility for benefits will not be based on my signing or refusing to sign this authorization, except if treatment is related to research, or if health care services are given to me only for creating protected health information for release to a third party.

RIGHT TO TAKE BACK AUTHORIZATION: I understand that I have the right to take back my authorization. If I take back my authorization, I have to notify the County in writing, I have to sign the notice, and I have to deliver the notice to the County at the following address**: Community Mental Health Services, Department of Health and Human Services, 250 Bon Air Road, Greenbrae, CA 94904.**

The notice will be in effect when received by the County. Any information already shared by this authorization cannot be taken back.

EXPIRATION: This authorization will go into effect immediately and will remain in effect until _____ (write in date). If I do not write in a date, this authorization will remain in effect for one year from the date of my signature.

Signature (*Client or Representative, as appropriate*)*:	Date (*month/day/year*):

** If form is signed by someone other than the client, state the relationship to client, and include required documentation of authority with the signed Authorization form.*

Name (*print*): _____

Relationship/ Authority: ☐ Parent ☐ Guardian ☐ Conservator ☐ Other _____ ☐ Personal Representative

Name of County Representative Who Receives this Form *(Print)*:	Date (*month/day/year*):

☐ **DISTRIBUTION:** Original copy of Authorization form to client's records, copy of Authorization form provided to client or representative.