County of Sacramento

Client-Initiated Authorization to Release Health Records

Records and Information Pertaining To:	DATE: / /	RECORD #:
LAST NAME:	FIRST NAME:	M.I.
SSN (LAST 4 DIGITS) OR ID:	DATE OF BIRTH: / /	
ADDRESS:	CITY/STATE/ZIP CODE:	

Enter the County of Sacramento program or clinic you authorize to release your confidential health information:

PROGRAM/AGENCY/OFFICE NAME:
ADDRESS:

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

☐ Entire Record (Excludes HIV, Mental Health & Alcohol/Drug Information)	☐ Lab Tests	☐ Attendance Only Records
☐ Include HIV or AIDS Information	☐ Medication	☐ Consultation Reports/Physician Order
☐ Include Alcohol/Drug Information	☐ Treatment/Personal Service Plan	☐ Progress Reports/Notes
☐ Include Mental Health Information	☐ Discharge Summary	☐ Psychiatric/Psychological Assessment/Testing Results
	☐ Social History	☐ Billing or Payment Information

☐ Medical Records relating to: _____

☐ Records from a specific visit or hospitalization (Enter date and location): _____

☐ Other (Please describe): _____

When does this Authorization expire? Date ____/____/____(mm/dd/yyyy) [no more than one year]

What is the purpose (s) for this release of confidential health information?

☐ At the request of the individual (client)

☐ OTHER: Please specify: _____

You authorize your confidential health information to be released to:

PROGRAM/AGENCY/OFFICE/ OR INDIVIDUAL'S NAME:		
ADDRESS:	CITY/STATE/ZIP CODE:	
CONTACT NAME:	PHONE #:	FAX#:

LAST NAME:	FIRST NAME:	M.I.:	DATE: / /

PROGRAM/AGENCY/OFFICE/ OR INDIVIDUAL'S NAME:		
ADDRESS:	CITY/STATE/ZIP CODE:	
CONTACT NAME:	PHONE #:	FAX#:

PROGRAM/AGENCY/OFFICE/ OR INDIVIDUAL'S NAME:		
ADDRESS:	CITY/STATE/ZIP CODE:	
CONTACT NAME:	PHONE #:	FAX#:

Important Note

Special kinds of health information have specific laws and rules that have to be followed before that information can be disclosed.

General Medical Records: Re-disclosure of these records is not allowed unless another authorization is obtained from you, or unless such disclosure is specifically required or permitted by federal or state law.

HIV, Alcohol and Drug, and Mental Health Treatment: These records are protected under federal or state law and cannot be disclosed without your written authorization unless otherwise provided. All HIV test information released must be labeled with a statement that: "This information may not be disclosed to any one without the specific written authorization of the individual."

I understand that my representative or I may revoke this authorization to obtain, use and disclose my information at any time in writing. I understand this change will not affect information that has already been shared. I understand that this authorization is voluntary; that my health information may be protected under federal or state confidentiality laws. I understand that these federal or state laws may not apply to the person or organization receiving the information being shared.

I understand that I have a right to a copy of this authorization.

Full Legal Signature or Mark of Individual		Date / /
Full Legal Signature of Representative	Relationship	Date / /
Signature of County Representative	Printed Name of County Representative	Date / /

Client-Initiated Authorization to Release Health Records INSTRUCTIONS

VERIFICATION: We are required to verify you have the authority to sign this form. You will need to provide picture identification, like a California state ID or a California driver's license. (See County HIPAA Privacy Rule Policy and Procedures for other acceptable forms of identification). You are required to attach a copy of the picture identification or present it in person.

VERIFICATION for Personal Representative: If the signer is a guardian or legal custodian of an adult, minor, emancipated minor or a representative of a deceased patient and is authorized by state law to act on behalf of the individual in making decisions about health care, a copy of the legal authority (guardianship or custody order) must be attached to this form. If the signer is a personal representative that does not have the legal authority, the client must provide documentation in writing appointing this person as a representative and this documentation must be attached.

ABOUT THE FORM: This authorization is a Voluntary Form. Be sure the individual understands it before signing.

EXPIRATION DATE: The expiration date cannot exceed one year from the client's signature date.

RIGHT TO REVOKE: The individual has a right to revoke this form. When an individual revokes written authorization to disclose information, the County of Sacramento must boldly mark the authorization form "revoked" and include the date and signature of the requesting individual.

COPY TO THE INDIVIDUAL: We must provide the individual with a copy of the signed authorization.

VALID AUTHORIZATION: THIS AUTHORIZATION IS NOT VALID IF:

- The expiration date has passed.
- The authorization has not been filled out completely, with respect to any applicable elements described below:
  - A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.
  - The name or other specific identification of the person authorized to make the requested use or disclosure.
  - A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
  - An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. The statement "end of the research study," "none," or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository.
  - Signature of the individual and date. If a personal representative of the individual signs the authorization, a description of such representative's authority to act for the individual must also be provided.