MERCED COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES
AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT INFORMATION (Complete as on-line form or print)

First Name:	Last Name:	Maiden Name / Aliases:
D.O.B. :	SSN: XXX-XX- (last 4 digits)	Telephone/Cell Phone #:
Dates of treatment / services covered by this form:	From:	To:

This form follows the State and Federal laws around the release and receipt of client protected health information (PHI).

I,_____ allow the following programs, agencies, and people to release to and communicate with each other as needed, to manage my care, treatment, financial obligations, maintain my records, and study results: (Please check the relevant boxes, initial beside each checked box, and provide names where needed.)

☒ _____ **Merced County Behavioral Health and Recovery Services (BHRS)**
☐ _____ Attorney/ Legal Rep _____
☐ _____ Central California Alliance for Health
☐ _____ Employment Development Department (EDD)
☐ _____ Hospital(s): _____
☐ _____ Merced County District Attorney _____
☐ _____ Merced County Human Services Agency: ○CPS ○CalWorks ○Other: _____
☐ _____ Merced County Jury Commissioner's Office
☐ _____ Merced County Probation Department _____
☐ _____ Merced County Public Defender _____
☐ _____ Merced County Public Health
☐ _____ Other Person or Agency _____
☐ _____ Other Person or Agency _____
☐ _____ Other Person or Agency _____
☐ _____ Parent/Guardian/ Spouse _____
☐ _____ Primary Care Physician: *(Dr. Name/Clinic)* _____
☐ _____ Presumptive Transfer Point of Contact _____
☐ _____ Public Conservator/Guardian _____
☐ _____ Residential Facility _____
☐ _____ School/ Staff _____
☐ _____ Social Security/ Disability
☐ _____ Superior Court of California/Juvenile Court
☐ _____ Superior Court Presiding/Assigned Judge

THE AGENCIES/ ENTITIES/ PERSONS LISTED ABOVE MAY REQUEST COPIES OF MY RECORDS: Exceptions: Information that I do **not want** released: _____ Initial Required

_____

_____

I understand the information I listed above cannot be released without my special consent, except when required by law. I also understand all limits in this agreement as to use, transfer, or disclosure of records.

INFORMATION WHICH MAY BE RELEASED:

I give special approval to release information about (Please check box(es) and initial to approve):

☐ Outpatient Psychiatric/ Mental Health _____ ☐ Substance Abuse _____
☐ Inpatient Psychiatric/ Mental Health _____ ☐ HIV Information _____

CLIENT NAME:_____ CLIENT ID:_____

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Disclosure includes the following information. Check ALL that apply.

☐ ASAM Results	☐ Billing	☐ Crisis Records
☐ Diagnosis/Problem List	☐ Drug Testing Results	☐ Evaluations/ Assessments/ Treatment Plans
☐ Lab Reports Treatment	☐ Prescription/ Medication Log	☐ Progress Notes
☐ Summary	☐ Other (Please be specific): _____	

If special form is submitted for doctor to complete (*Please specify name of form*): _____

REVOCATION OF AUTHORIZATION

Client/ Legal Representative Signature: _____

Date (MM/DD/YYYY): _____

If signed by legal representative, authority/relationship to client: _____

☐ Written notice received via US Mail by Medical Records. **(For BHRS use only)**

DATE AGREEMENT EXPIRES (no more than one year from signature date): _____

EXCLUSION ON INFORMATION USE, TRANSFER, OR REDISCLOSURE: Except when required by state or federal laws, user of released information for other than the stated purpose of redisclosure or transfer of this information to any person or entity not named on this form is barred. Another written agreement must be obtained for any proposed new use, redisclosure or transfer of the information. Authorized information may be subject to redisclosure by the receiver and no longer protected by the privacy rules.

MINORS: By federal rules in drug/alcohol abuse or HIV/AIDS related material then both the client and parent, guardian or other person authorized to act by state law must sign on his/her behalf is required.

CLIENT RIGHT TO RECEIVE A COPY OF THE AGREEMENT:

I have received a copy of this agreement ☐Yes ☐No

I understand that allowing the use or disclosure of the information identified above is voluntary. Merced County BHRS will not condition treatment, payment, enrollment, or eligibility of benefits on whether I sign this agreement.

_____ _____

Signature of Client/ Legal representative* Date

* If signed by legal representative, authority/relationship to Client: _____

For Staff Use Only

Proof of client's ID at time of signature was completed and confirmed by my signature.

Witness (Staff) Printed Name: _____

Signature: _____ Date: _____

CLIENT NAME: _____ CLIENT ID: _____