Authorization to
Release Health and Mental Health Records

Nekita Noel-Ikulala, ASW# 86291
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(916) 581-0393

Records and Information Pertaining To	Date:	Authorization will expire on:
Last Name:	First Name:	Date of Birth:
Address:		

Check mark the types of confidential information to be released

☐ Entire Record (excludes HIV, Mental Health & Alcohol/Drug Info)	☐ Lab Tests	☐ Attendance Only Records
☐ Include HIV or AIDS Information	☐ Medication	☐ Consultation Reports/ Physician Orders
☐ Include Alcohol/Drug Information	☐ Treatment or Personal Service Plan	☐ Progress Reports/Notes
☐ Include Mental Health Information	☐ Discharge Summary	☐ Psychiatric/Psychological Assessment/Testing Results
☐ Medical Records relating to	☐ Social History	☐ Billing or Payment Information
☐ Records from a specific visit or hospitalization (enter date and location)		
__ Other		

Requesting information from the following provider/agency or person:

Program/Agency/Office Name		
Address:	City/State:	Zip Code:
Telephone Number:	Fax Number:	Contact Name (if known):

Specifically write the purpose(s) for obtaining this confidential health information

Important Note

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 may choose not to sign this authorization and this will not affect my ability to obtain treatment or payment or my current eligibility for health care benefits.

Full Legal Signature or Mark of Individual — Date

Full Legal Signature of Representative — Relationship — Date

Signature of Witness — Date

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.

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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 HIPAA Privacy 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. In addition, if this release is for an event – enter the event expiration 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: If our program initiates this authorization from an 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 or the one time event is known by the covered entity to have occurred.

- ❑ 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.