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SAN MATEO COUNTY HEALTH
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AUTHORIZATION FOR RELEASE OF WRITTEN OR VERBAL HEALTH INFORMATION

YOUR INFORMATION

Last Name/First Name:	Date of Birth:
Address:	City/State/Zip:
Medical Record Number:	Other Patient ID:

AUTHORIZATION

I HEREBY AUTHORIZE: (Party Releasing Information)	TO RELEASE TO: (Party Receiving Information)
Name:	Name:
Role/Relationship:	Role/Relationship:
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone:	Phone:
Fax:	Fax:

DESCRIPTION OF THE INFORMATION TO BE RELEASED

Provide a detailed description of the specific information to be released

☐ All Dates **OR** Enter date range for the records to be released:
_____(date) to_____(date)

*Please indicate the information you would like to release by selecting OPTION 1 **or** OPTION 2*

OPTION 1

☐ Entire record including all medical/mental health, alcohol and drug, and HIV/AIDS information (this includes the release of all information below)

(Continued on second page)

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OPTION 2

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

General Information	**Medical Information**	**Alcohol and Drug-Specific Information** (excludes psychotherapy notes)	**Mental Health Information** (excludes psychotherapy notes)
☐ Demographic Information ☐ Discussion of my care with my physician ☐ Make medical appointment(s) for me ☐ Financial Information ☐ View my patient information ☐ My general status in a program, including goals, services I receive, and how to support my progress	☐ Any medical information related to my care **OR** Only the following medical information (check all that apply) ☐ Medications ☐ Assessments ☐ Treatment Plan & Recommendations ☐ Discharge Summary ☐ Lab Results ☐ HIV/AIDS Test Results ☐ Dental Information	Only the following alcohol and drug-specific information (check all that apply) ☐ Medications ☐ Assessments ☐ Diagnoses ☐ Treatment Plan & Recommendations ☐ Discharge Summary ☐ Lab Results	Only the following mental health information (checkall that apply) ☐ Medications ☐ Assessments ☐ Diagnoses ☐ Treatment Plan & Recommendations ☐ Discharge Summary ☐ Lab Results

☐ Only the following information/other information (please specify below):

PURPOSE

The purpose and limitations (if any) of the requested use or disclosure is/are:

Patient Request; ***OR***

Other:_____

This authorization for release of the above information to the above named person(s) or organization(s) shall become effective immediately and shall remain in effect for one year from the date of signature**,** unless a different date is specified.

Enter date range here if less than one year:

For the following period of time:_____(date) to_____(date)

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I understand that: I authorize the use and/or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary. I have the right to cancel this authorization at any time by contacting the SMCHS that office prepared my records, in writing. The authorization will end on the date my valid, written cancellation request is received. For federally-assisted substance abuse programs and records subject to the Lanterman Petris Short (LPS) Act a verbal revocation must be accepted. The Notice of Privacy Practices provides instructions for me, as well as limitations on my cancellation, should I decide to revoke my authorization. My treatment, payment, enrollment or eligibility for benefits will not be affected if I do not sign this authorization. I have the right to receive a copy of this authorization and to obtain information on the disclosures made pursuant to this authorization. Reasonable fees may be charged to cover the costs of copying and postage. Under California law, the recipient of my medical information is prohibited from re-disclosing the information, except with a written authorization or as specifically required or permitted by law. If the organization(s) or person(s) I have authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Print Name of Client/Patient/Authorized Representative	Signature
Date/Tim	If signed by someone other than the patient/client, include name and relationship

Patient/Client Primary Language	Interpreter name (as applicable)	Interpreter number (as applicable)