San Mateo County Behavioral Health and Recovery Services
Alcohol and Other Drugs (AOD) Services Unit

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information as set forth below, consistent with California and Federal law concerning the privacy of such information. **Failure to provide *all* information requested may invalidate this Authorization.**

I, (Client Name) _____ DOB _____

Authorize the exchange of health information (as specified below) between

San Mateo County Behavioral Health and Recovery Services – AOD Unit

Staff/Program _____

AND the following person/organization:

Name _____

Address _____

Tel _____ Fax _____

This Authorization applies to the following information (Initial one or more):

____ Assessment reports, including diagnosis
____ Treatment Plan/Recommendations
____ Discharge Summary
____ Entire AOD record with history of mental and physical condition and treatment provided, including HIV/AIDS
____ Only the following health information: _____
____ Only information from (Date) _____ to (Date) _____

This information will be used for the following purpose(s): (Initial one or more)

____ Coordinating services/Referrals
____ Assessment/Treatment
____ Consultation/2nd opinion
____ Other (Specify): _____

Client Name _____

This Authorization shall be valid for one year from the date signed, or until (date):

_____

RESTRICTIONS

Federal and California law prohibits recipients of your health information from re-disclosing such information except with your written authorization or as specifically required or permitted by law. However, if you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected.

MY RIGHTS

I may refuse to sign this Authorization. I may inspect or obtain a copy of the protected health information that is being disclosed. I have a right to receive a copy of this Authorization. I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address:

_____

My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this Authorization. **Treatment, payment, enrollment and/or eligibility for benefits will not be based on my providing, or refusing to provide, this Authorization.**

Signature _____ **Date** _____
(Client/Legal Representative)

If signed by someone other than the client, description relationship: _____

_____

Witness of Client/Representative Signature _____