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Jamestown, CA 95327
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Mathiesen.clinic@crihb.org

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)
BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER

I. PATIENT INFORMATION			
Last Name:	First Name:		MI:
Street Address:	City:	State:	Zip:
Medical Record Number: Office Use Only	Date of Birth (MM/DD/YYYY)	Phone Number:	

II. RECIPIENT INFORMATION			
Recipient Name: ***(If the recipient is a an entity with no treating provider relationship, include the name of the entity and the specific individual or position authorized to receive the information)***			
Street Address:	City:	State:	Zip:
Email:	Fax Number:	Phone Number:	

III. SCOPE OF DISCLOSURE

PURPOSE (Required)**:** The health information disclosed may only be used for the following purpose(s):

☐ Patient Request (Note: Select this option if you are requesting records for your own personal use.)

☐ Child Welfare Services (CWS) Oversight (Note: Select this option to authorize the release of information directly to CWS for specific purposes related to their direct oversight of a case. Ensure all applicable purposes are checked.):

- ☐ To assess the environmental safety and welfare of child(ren) involved in ongoing CWS case.
- ☐ To evaluate the stability of the home environment to determine its suitability for child welfare.
- ☐ To provide necessary information for court proceedings or legal investigations conducted under CWS oversight.

☐ Other (specify)_____

List limitations of disclosure, if any:

Rev. 05/2024

BEHAVIORAL HEALTH:

I specifically authorize release of the following Behavioral Health records. **Initials:** _____

☐ All Behavioral Health Records (includes all items listed below)

☐ Psychiatric Evaluation ☐ Psychiatric Progress Summary ☐ Psychosocial Assessment

☐ Phycological Testing Summary ☐ Psychological Evaluation ☐ Behavioral Health Treatment Plan

☐ Lab Results ☐ Progress Notes ☐ Case Management/Care Coordination

☐ Primary Care Records Included in Behavioral Health Records

☐ Other - Specific information pertaining to: _____

Date Range: _____ to _____
MM DD YYYY MM DD YYYY

_____ _____
Behavioral Health Provider's Signature **Date**

SUBSTANCE USE DISORDER (SUD):

I specifically authorize release of the following Substance Use Disorder records. **Initials:** _____

☐ All Substance Use Disorder Information (includes all items listed below)

☐ Assessment ☐ Diagnosis ☐ Attendance ☐ Client Plan ☐ Discharge Plan/Summary ☐ Lab Results

☐ Summary Letter ☐ All SUD Claims and Encounter Data ☐ Treatment Plans ☐ Progress Notes

☐ Case Management/Care Coordination ☐ Drug test results

☐ Primary Care Records Included in SUD Records ☐ Behavioral Health Records Included in SUD Records

☐ Medication/Dosage

☐ Other: _____

Date Range: _____ to _____
MM DD YYYY MM DD YYYY

IV. EXPIRATION

This Authorization will automatically expire ONE (1) YEAR from the date of execution unless a different end date is specified here: _____

V. AUTHORIZATION INFORMATION

By signing this Authorization, I understand that:

- **Confidentiality of SUD Records**: My Substance Use Disorder records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 and 164. These records cannot be disclosed without my written consent unless otherwise provided for by the regulations.
- **Voluntary Authorization**: This Authorization is voluntary, and I am not required to sign this Authorization to receive treatment, enroll in services, or secure payment for my health care.
- **Copy of Authorization**: I have the right to receive a copy of this Authorization. A copy of this Authorization is as valid as the original.
- **Revocation**: I have the right to revoke this Authorization for future releases at any time by submitting a written request to the Mathiesen Memorial Health Clinic. I may use the Revocation of Authorization form located at Section VIII below or submit a separate letter. The revocation should be mailed or delivered directly to the facility where I provided this Authorization. My revocation will not affect any actions taken or any information released prior to the clinic receiving my revocation notice.
- **Further Disclosure**: If the individual(s) or entity(ies) authorized to receive or use my health information are not legally required to keep it confidential, they may further disclose the health information, and it may no longer be protected by federal or state privacy laws.
- **Electronic Release of Information**: Information authorized for release may be released electronically.

VI. PROHIBITION ON RE-DISCLOSURE OF PROTECTED SUD INFORMATION

Title 42 Code of Federal Regulations Part 2 prohibits unauthorized disclosure of these records.

VII. SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

I have read and understand the content of this Authorization. I am signing the Authorization voluntarily, and understand that I have the right to refuse to sign this document. My signature authorizes the disclosure of the health information as described in Section III of this Authorization.

Signature of Patient or Legal Representative:

_____ **Date:** _____

If signed by Patient's Legal Representative, state relationship and authority to do so:

Patient is: ☐ Minor ☐ Incompetent/Incapacitated ☐ Deceased

Relationship: _____

Legal Authority:

☐ Legal Guardian ☐ Spouse of Deceased ☐ Health Care Agent ☐ Personal Representative

☐ Health Care Provider/PCP ☐ Other: _____

VIII. REVOCATION OF AUTHORIZATION

☐ **I wish to revoke my authorization.**

*Please send or deliver the Revocation of Authorization to Mathiesen Memorial Health Clinic, whose contact information is listed above.

Name and Signature of Patient or Legal Representative:

Print Full Name: _____

Signature: _____ **Date:** _____

If signed by Patient's Legal Representative, state relationship and authority to do so:

Patient is: ☐ Minor ☐ Incompetent/Incapacitated ☐ Deceased

Relationship: _____

Legal Authority:

☐ Legal Guardian ☐ Spouse of Deceased ☐ Health Care Agent ☐ Personal Representative

☐ Health Care Provider/PCP ☐ Other: _____

Office Use Only

Verification of ID: ☐ **Yes** ☐ **No** **Staff Initials:** _____ **Date:** _____

If no, ☐ **Records sent to other Provider's office** ☐ **Records sent to** _____

Date Received: _____

Date Completed: _____ **Staff Initials:** _____

Patient Information Label