Authorization Request from the Client/Individual
Client Initiated Release of Health Records

DEPT. OF HEALTH AND HUMAN SERV.

9616 MICRON AVE, SUITE 850-B, SACRAMENTO, CA 95827

Records and Information Pertaining To	DATE:	RECORD #:
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
SSN OR ID:	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/ 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		

Authorization will expire on _____ date.

I authorize the County of Sacramento to send the above identified health information to the following person, program, agency, or office.

PERSON/PROGRAM/AGENCY/OFFICE NAME		
ADDRESS:	CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:	FAX NUMBER:	CONTACT NAME (IF KNOWN):

PERSON/PROGRAM/AGENCY/OFFICE NAME		
ADDRESS:	CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:	FAX NUMBER:	CONTACT NAME (IF KNOWN):

PERSON/PROGRAM/AGENCY/OFFICE NAME		
ADDRESS:	CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:	FAX NUMBER:	CONTACT NAME (IF KNOWN):

PERSON/PROGRAM/AGENCY/OFFICE NAME		
ADDRESS:	CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:	FAX NUMBER:	CONTACT NAME (IF KNOWN):

PERSON/PROGRAM/AGENCY/OFFICE NAME		
ADDRESS:	CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:	FAX NUMBER:	CONTACT NAME (IF KNOWN):

Important Note

Special kinds of health information have specific laws and rules that have to be followed before that information can be disclosed.

HIV, Alcohol and Drug, and Mental Health Treatment: These records are protected under federal or state law and cannot be disclosed without your written authorization unless otherwise provided. Re-disclosure of these records is not allowed, except in compliance with state or federal law or with your written permission. All HIV test information released must be labeled with a statement that: "This information may not be disclosed to any one without the specific written authorization of the individual."

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.

Full Legal Signature or Mark of Individual   Date

Full Legal Signature of Representative   Relationship   Date

Signature of County Representative   Date