



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

Sacramento County Primary Care Center

4600 Broadway, Suite 1100 Sacramento, CA 95820

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

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

Important Note

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

General Medical Records: Redisclosure of these records is not allowed unless another authorization is obtained from you, or unless such disclosure is specifically required or permitted by federal or state law.

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. 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.

I understand that I have a right to a copy of this authorization.

Full Legal Signature or Mark of Individual Date

Full Legal Signature of Representative Relationship Date

Signature of County Representative Date