

Countywide Services Agency



Terry Schutten, County Executive
Penelope Clarke, Agency Administrator

Department of Health and
Human Services

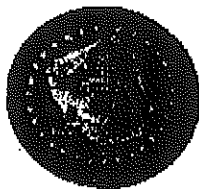
Lynn Frank, Interim Director

County of Sacramento

Preferred Identification is a current Drivers License or State ID Card that is not mutilated or altered. If the client has one of these not other identification is required.

If the client does not have, one of the items above, the following can be used in lieu of a valid pictured identification. The individual is required to have two of these items in any combinations:

- Military ID with signature
- Military discharge papers
- Government Employee Badges, with signature, issued in the last five years
- Jail property receipt or release papers with signature
- Naturalization papers or immigration cards with signatures
- Authorized Certified Copy of Birth Certificate for California residents (Copy with notation "Not To Be Used For Identification" is **not** acceptable)
- Passport with signature
- Marriage license or certificate with signature
- Fishing or hunting license with signature and issue in the last five years
- Hospital patient bracelet when it has not been removed from arm
- Food Stamp ID card, with signature, issued within the last two years
- Laminated check cashing card with picture and signature



Authorization to Release Health Records

Insert Program Name here

Insert Program Address here

Instructions:

VERIFICATION: We are required to verify you have the authority to sign this form. You will need to provide picture identification, like a California state ID or a California driver's license. (See HIPAA Privacy policy and procedures for other acceptable forms of identification). You are required to attach a copy of the picture identification or present it in person.

VERIFICATION for Personal Representative: If the signer is a guardian or legal custodian of an adult, minor, emancipated minor or a representative of a deceased patient and is authorized by state law to act on behalf of the individual in making decisions about health care, a copy of the legal authority (guardianship or custody order) must be attached to this form. If the signer is a personal representative that does not have the legal authority, the client must provide documentation in writing appointing this person as a representative and this documentation must be attached.

ABOUT THE FORM: This authorization is a **Voluntary Form**. Be sure the individual understands it before signing.

EXPIRATION DATE: The expiration date cannot exceed one year from the client's signature date.

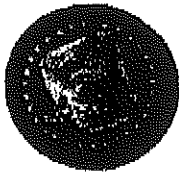
RIGHT TO REVOKE: The individual has a right to revoke this form. When an individual revokes written authorization to disclose information, the County of Sacramento must boldly mark the authorization form "revoked" and include the date and signature of the requesting individual.

COPY TO THE INDIVIDUAL: We must provide the individual with a copy of the signed authorization.

VALID AUTHORIZATION: THIS AUTHORIZATION IS NOT VALID IF:

- The expiration date has passed or the one time event is known by the covered entity to have occurred.
- The authorization has not been filled out completely, with respect to any applicable elements described below
 - A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.
 - The name or other specific identification of the person authorized to make the requested use or disclosure.
 - A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
 - An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. The statement "end of the research study," "none," or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository.
 - Signature of the individual and date. If a personal representative of the individual signs the authorization, a description of such representative's authority to act for the individual must also be provided.

Insert Program specific instructions here or DELETE this line before use.



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

Insert Program Name here

Insert Program Address here

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