KERN COUNTY MENTAL HEALTH SYSTEM OF CARE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize _____ to release/exchange records/information
(Name of Hospital/Agency /Individual or Class of Individuals)

in the course of the diagnosis and treatment of: _____
(Full Name of Individual-Served, include A.K.A's)

_____, _____ for mental health purposes and/or conditions
(Date of Birth) (Social Security #)

related to alcohol and/or substance abuse to: _____
(Name of Hospital/Agency/Individual or Class of Individuals to which disclosure is made)

_____
(Address and Phone Number of Hospital/Agency/Individual or Class of Individuals to which disclosure is made)

The release/exchange of records or information authorized herein is required for the following purpose:

_____

Such disclosure will be limited to the following information: _____
(If HIV/AIDS information is to be released, this must be specifically noted)

_____

- I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment unless KCMH requires authorization to determine my eligibility for mental health services.
- I understand that I have a right to revoke this authorization at any time. My revocation must be made in writing to my treatment team. I cannot hold this entity liable for any information released prior to the written revocation.
- This authorization shall terminate on _____ or when the following event occurs_____.
- If not revoked or terminated earlier, this authorization shall terminate exactly one year from the date of this authorization or when my case is closed, whichever occurs first.
- I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations then such information may be re-disclosed and would no longer be protected.

_____ _____
Individual-Served Date

_____ _____
Parent/Guardian/Conservator Date

_____ _____
Staff Member Date

*(NOTE: **LPHA must sign approval if PHI is released to a 'person' vs. a 'professional')***

____ **My initials indicate that a staff member has: a) discussed with me the effects of releasing this information and b) given me a copy of this authorization.**

TO THE RECEIVER OF THIS INFORMATION-NOTE: Recipient of this information is subject to the Lanterman-Petris-Short Act confidentiality provisions and may not further disclose this information unless the patient or legal representative authorizes the disclosure. Violations of the requirements set forth by the Lanterman-Petris-Short Act can subject the releasor and/or recipient to a $10,000 fine.