PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the Sonoma County Department of Health Services to disclose the protected health information of: _____
(Client Name)

To: _____
(Name(s) or Title(s) of Person(s) or Organization(s) Receiving Records)

I authorize the use or disclosure of protected health information including but not limited to: physical health records; mental health records, including those records protected by the Lanterman-Petris-Short Act; Drug and/or alcohol abuse records protected by 42 CFR Part 2; Sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) records; Human immunodeficiency virus (HIV) records.

Please specify any restrictions on the use or disclosure of your health information:

_____

_____

The information may be used and disclosed for the following purposes; including: Treatment including review and/or coordination of health care services with multiple providers. Referrals to other agencies for the purposes of providing public benefits and/or services. Research and/or registries and databases. Development of training programs for clinical staff and independent practitioners.

[ ] **Other – Please Specify** _____

This authorization is effective immediately and will remain in effect until:

_____.
(Please specify a date or event.)

I understand that all information, including my records are protected under the federal register 42 CFR Part 2 governing confidentiality of Alcohol and Drug Abuse Patient/Client Records and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) CFR 45 Parts 160 and 164 and shall not be disclosed without my written consent unless otherwise permitted by law. Redisclosures of information may not be protected by federal HIPAA regulations.

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing. My written request to revoke this authorization must be submitted to DHS 3313 Chanate Road, Santa Rosa, CA 95404. I understand that the revocation will not apply to information that has already been released in reliance on this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

To be valid, all requested information must be provided, authorization must be signed and dated.

I understand that I have the right to refuse to sign this authorization. My refusal to sign this authorization will not impact my ability to receive treatment, payment, or enrollment and eligibility for benefits.

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

Signed: _____ **Dated:** _____

If not signed by the patient, please indicate relationship:

[ ] parent or guardian of minor patient
[ ] guardian or conservator of an incompetent patient
[ ] beneficiary or personal representative of deceased patient
[ ] other please specify legal authority_____

Signed: _____ **Dated:** _____

To be valid, all requested information must be provided, authorization must be signed and dated.