SOUTH COAST MEDICAL CENTER
CONSENT FOR RELEASE OF SUBSTANCE ABUSE PATIENT INFORMATION OR RECORDS

I hereby authorize South Coast Medical Center to disclose records obtained in the course of the diagnosis

and treatment of [name of patient] ______________________________ [date of birth] ____________

for alcohol and/or drug abuse to:

[name of person or organization to which disclosure is made] ______________________________

[address] ____

[city,state,zip] ______________________________________ [phone] ____________

THE FOLLOWING INFORMATION MAY BE RELEASED (CHECK):

- ☐ History and Physical
- ☐ Emergency Room
- ☐ Pathology Reports
- ☐ Other - Please Specify: ______________________________
- ☐ X-Ray Reports
- ☐ Discharge Summary
- ☐ Consultation
- ☐ Operative Reports
- ☐ Lab Reports

FOR THE PURPOSE OF (CHECK):

- ☐ Patient Care
- ☐ Insurance Claim
- ☐ Legal Review
- ☐ Other - Please Specify: ____________________
- ☐ Medical Review

DURATION:

This authorization shall become effective immediately and shall remain in effect until [date] ____________, unless otherwise revoked.

Date:____________________ Time:______________A.M./P.M.

Signature:____
(Patient/parent/conservator/guardian)

If signed by other than patient, indicate relationship:______________________________

Witness:____

Additional Copy:

I further understand that I have a right to receive a copy of this authorization upon request. Copy requested:

☐ YES ☐ NO

Confidentiality notice given: ☐ YES ☐ NO

South Coast Medical Center

Adventist Health

31872 Coast Highway
Laguna Beach, CA 92651

CONSENT FOR RELEASE OF SUBSTANCE ABUSE PT. INFORMATION OR RECORDS

SOUTH COAST MEDICAL CENTER
CONSENT FOR RELEASE OF MENTAL HEALTH PATIENT INFORMATION OR RECORDS

I, [patient] ______________________________, [date of birth] ____________________, [phone number]________________________, hereby authorize South Coast Medical Center, it's administrator, or his/her designee, to disclose records and information obtained in the course of my diagnosis and treatment to [name of person or organization to which disclosure is made] ____________ [address,city,state,zip]________________________________

THE FOLLOWING INFORMATION MAY BE RELEASED (CHECK):

- ☐ History and Physical
- ☐ Emergency Room
- ☐ Pathology Reports
- ☐ Other - Please Specify: ____________________
- ☐ X-Ray Reports
- ☐ Discharge Summary
- ☐ Consultation
- ☐ Operative Reports
- ☐ Lab Reports

FOR THE PURPOSE OF (CHECK):

- ☐ Patient Care
- ☐ Insurance Claim
- ☐ Legal Review
- ☐ Other - Please Specify: ____________________
- ☐ Medical Review

ADDITIONAL COPY:

I further understand that I have a right to receive a copy of this authorization upon request. Copy requested:

☐ YES ☐ NO

Signature:____
(Patient/legal representative/spouse*/financially responsible party*) (Date) (Time)

If signed by other than patient, indicate relationship:________________ Witness:________________

The undersigned, the physician, licensed psychologist, or social worker with a master's degree in social work, who is in charge of the patient, hereby (approve ☐) (disapprove ☐) the release of information and records to the party specified above. If disclosure is disapproved, give reason below. Also note below any restrictions on the release of records.

NOTE: No approval is required for release to the patient's attorney, parent of minor, guardian, or conservator.

Reason for disapproval: ____

Date: ______________________________

Signature: ____
[Physician/Psychologist/Social Worker]

Degree: ____

Reference: Welfare & Institutions Code section 5328.7

South Coast Medical Center
Adventist Health
31872 Coast Highway
Laguna Beach, CA 92651

CONSENT FOR RELEASE OF MENTAL HEALTH PT. INFORMATION OR RECORDS

6/98)