AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Information:

First Name: __________________________ **Last Name:**_________________________________

Date of Birth: ________________________**Phone Number:**____

Address:____

City:_________________________________**State:**_____________**Zip Code:**____________________________

I hereby authorize:
Sacramento Behavioral Healthcare Hospital, 1400 Expo Parkway, Sacramento, CA 95815
to release protected health information to:

☐Self	☐Provider	☐Other:________________________
Name:		
Address:		
Phone:	Fax:	
☐Mail	**☐Pick Up (photo ID REQUIRED)**	**☐Fax to provider**

I am requesting copies of the following:

☐ Dates of Stay Letter

☐ Discharge Packet (History & Physical, Psychiatric Evaluation, Labs, Discharge summary)

☐ Other: ____

____

Dates of service to be released (required): ____

By initialing below, I signify that I consent for the following type(s) of information to be released:
______ Substance Abuse ______ Psychiatric Conditions
______ HIV test results (separate consent required for each release of HIV test results)

Purpose for which the information will be disclosed:
☐Continuing Care ☐Legal Purposes ☐Personal Use ☐Other:__________________

This form may be submitted to:
Sacramento Behavioral Healthcare Hospital, 1400 Expo Parkway, Sacramento, CA 95815
Fax: (916) 437-6594

Sacramento Behavioral Healthcare Hospital

Authorization Disclosure:
I understand that I have the following rights with respect to this authorization:

1. I understand that information to be released may include information regarding drug or alcohol abuse, psychological or psychiatric impairments, confidential communications, HIV and/or AIDS, physical conditions or other information which may be privileged or confidential under State and/or Federal law.
2. The recipient of the protected health information is prohibited from redisclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law.
3. I may not be required to sign this authorization as a condition to obtaining treatment or payment or my eligibility for benefits.
4. I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to Sacramento Behavioral Healthcare Hospital, 1400 Expo Parkway, Sacramento, CA 95815. Such revocation will be effective upon receipt.

Under California law, a health care provider may decline to permit inspection or provide copies of mental health records only if the provider determines there is a substantial risk of significant adverse or detrimental consequences to a patient in seeing or receiving a copy of her/his mental health records. If determined, the health care provider shall make a written record, to be included with the mental health records requested, noting the date of the request and explaining the health care provider's reason for refusing to permit inspection or provide copies of the records, including a description of the specific adverse or detrimental consequences to the patient that the provider anticipates would occur if inspection or copying were permitted. The health care provider shall permit inspection by, or provide copies of the mental health records to, a licensed physician and surgeon, licensed psychologist, licensed marriage and family therapist, licensed clinical social worker, or licensed professional clinical counselor, designated by request of the patient.

The confidentiality of medical, psychiatric and substance abuse information is protected by state and federal statutes, rules and regulations (including California Confidentiality of Medical Information Act; California Administrative Code, Title 22, California Welfare and Institutions Code, Section 5328; and Title 42 of the Code of Federal Regulations). These statutes and rules and regulations require that the patient give informed consent prior to the release of any health/hospital records or information, except as specifically provided for within the statutes, rules and regulations.

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

Signature of Patient:	**Date:**
Witnessed by:	**Date:**
Signature of Parent/Legal Guardian:	**Date:**
Witnessed by:	**Date:**