AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Failure to provide all information may invalidate this authorization.

PATIENT NAME: _____
DATE OF BIRTH: _____ PHONE: _____
ADDRESS: _____
CITY, STATE, ZIP CODE: _____

I authorize Santa Rosa Behavioral Healthcare Hospital (SRBHH)

☐ Release To:
☐ Request From:

Person/Organization: _____
Address: _____
City, State, Zip Code: _____
Phone: _____ FAX: _____

For the following purpose(s):
☐ Continuing Care ☐ Insurance
☐ Legal ☐ Personal Use
☐ Other (Please specify) _____

Treatment Date(s): _____
☐ History and Physical Report ☐ Discharge Summary
☐ Psychiatric Evaluation ☐ Medications
☐ Progress Notes ☐ Lab Results
☐ Other (Please specify) _____

State/Federal Laws require specific authorization to release the following types of information:
☐ Alcohol/Substance Abuse
☐ Infectious Disease (example: STDs, HIV, AIDS)
☐ Psychotherapy Notes

NOTICE OF RIGHTS

I understand that:

1. If I refuse to sign this authorization, my refusal will not affect my ability to obtain treatment.
2. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
3. I may revoke this authorization at any time in writing, signed by me or by my representative and delivered to: Santa Rosa Behavioral Healthcare Hospital, 1287 Fulton Road, Santa Rosa, CA 95401.
4. If I revoke this authorization, the revocation will not have any effect on any actions taken prior to receiving the revocation.
5. I have a right to receive a copy of this authorization.
6. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it, unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

EXPIRATION

Without my written revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 365 days from the date hereof, unless otherwise specified: _____

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Print Name of Patient or Patient's Representative Relationship to Patient

PLEASE RETURN THIS FORM BY:

Mail: Santa Rosa Behavioral Healthcare Hospital, 1287 Fulton Rd, Santa Rosa, CA 95401

OR

Fax: (707) 800-7798

For more information about this form, please contact the Privacy Officer at (707) 800-7762.