# AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

*(HIPAA & 42 CFR Part 2 Compliant)*

## PATIENT INFORMATION

**Patient Name (Print):** ________________________________________ **Date of Birth:** ____/____/______

## AUTHORIZING FACILITY

I authorize **Santa Rosa Behavioral Healthcare Hospital** 1287 Fulton Road, Santa Rosa, CA 94501 Phone:(707)800-7761 Fax:(707)800-7798 to use and/or disclose my health information as described below.

## PERSON(S) / ENTITY AUTHORIZED TO RECEIVE INFORMATION

(Please select one option below):

☐ Specific person or organization (example: a family member, parole officer, outside provider):

Name: ______________________________________ Relationship to Patient: ______________________

Name: ______________________________________ Relationship to Patient: ______________________

☐ Group of providers or organization involved in my care, such as:

- Treating doctors and care teams
- Health Plans / Insurance companies
- Care coordination or referral partners
- Legal team

Organization Name (If Applicable): ______________________________ Address: ___________________

City / State / Zip: ____________________________________Phone / Fax: _________________________

## PURPOSE OF DISCLOSURE

(Check all that apply)

☐ At my request ☐ Treatment/Continuity of Care ☐ Billing/Insurance Claims

☐ Legal Purposes ☐ Other: _____________________________________________________

## INFORMATION TO BE RELEASED

*(Check all that apply – Disclosure limited to items selected)*

☐ Admission / Discharge Summary ☐ History & Physical ☐ Psychiatric Evaluation

☐ Medication Records ☐ Treatment Plans ☐ Progress Notes ☐ Labs ☐ Billing

☐ Other (Specify) ________________________________

Date Range of Records: ___/____/_______to ____/______/_________

## SUBSTANCE USE DISORDER (SUD) RECORDS

I understand that my records may include substance use disorder (SUD) information protected under federal law (42 CFR Part 2).

☐ I authorize the release of SUD records, including alcohol and/or drug treatment information.

## SENSITIVE INFORMATION

☐ HIV/AIDS Test Results, Initial: ________

## PSYCHOTHERAPY NOTES – Separate AUTHORIZATION REQUIRED

Psychotherapy notes are afforded **special protection under federal and California law** and are **not included** in general medical records.

☐ **I Specifically authorize** the release of psychotherapy notes.

**Initials** (required): ________________ *(If not initialed, psychotherapy notes will not be released.)*

## EXPIRATION

This authorization will expire:
One (1) year from the date signed ☐ On the following date: _____/_____/_______

## YOUR RIGHTS

- I understand that I may **revoke this authorization at any time** by submitting a written request to SRBHH. Revocation will not apply to information already disclosed.
- I understand that **treatment, payment, enrollment, or eligibility for benefits is not conditioned** on signing this authorization.
- I understand that I have the **right to receive a copy** of this authorization.

## REDISCLOSURE NOTICE

Information disclosed under this authorization may be subject to redisclosure and may no longer be protected by federal HIPAA privacy regulations. However, Substance Use Disorder records protected under 42 CFR Part 2 remain protected and may not be redisclosed unless permitted by federal law.

## SIGNATURES

☐ Signature of Patient ☐ Conservator ☐ Legal Guardian ☐ Authorized Representative:
Name (Print) ______________________________ Relationship: ____________________________
Signature: ________________________________________________ Date: ____/ ____/ ________

## CALIFORNIA LAW NOTICE

Under California law, a health care provider may decline to permit inspection or provide copies of mental health records only if there is a **substantial risk of significant adverse consequences** to the patient. If access is denied, the patient may designate a licensed physician, psychologist, marriage and family therapist, or licensed clinical social worker to inspect the records.

## FOR FACILITY USE ONLY

Records Released:

☐ Discharge Summary ☐ Psychiatric Evaluation ☐ H&P ☐ Medication Records

☐ Treatment Plans ☐ Progress Notes ☐ Labs ☐ Other: ________________

**Processed By:** _______________________ **Date:** ____/_____/_________

**Method:** ☐ Fax ☐ Secure Email ☐ Mail ☐ In Person

| **AUTHORIZATION TO RELEASE MEDICAL/PSYCHIATRIC INFORMATION SANTA ROSA BEHAVIORAL HOSPITAL**<br>1287 Fulton Road, Santa Rosa, CA 95401 | **Patient Identification:** |
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