AUTHORIZATION TO RELEASE MEDICAL, PSYCHIATRIC, ALCOHOL, SUBSTANCE USE RECORDS, HIV RELATED INFORMATION (RELEASE OF INFORMATION) – ROI

PATIENT INFORMATION:

Patient/Client Name _____ OK to leave a message? Yes No

DOB _____ SSN _____ Telephone _____

Maiden Name/Other Name Used in the Past _____

Dates of treatment covered by this authorization: From _____ To Current

EXPLANATION:

This authorization conforms to requirements of State and Federal laws governing release and receipt of Protected/Patient Health Information (PHI).

AUTHORIZATION:

I hereby authorize the following healthcare provider/agency to disclose information from my records to the recipient(s) listed below, even though such information is otherwise confidential and/or privileged.
I hereby authorize reciprocal release from my records to the recipient(s) listed below ☐

FROM: Name *San Joaquin County Behavioral Health Services* Phone *(209) 468-8765*
Address *1212 N. California Street*
City, State, Zip Code *Stockton, CA 95202*

TO WHOM: Name Hoosier Services Inc. Phone 800-882-4156
Address 18032 Lemon Drive,#C-618
City, State, Zip Code Yorba Linda, CA 92886

PURPOSE(S): State reason records are being requested (Please select one from the list)

◯ Continuing Health Care ◯ Communication
◯ View My Records ◯ Receive a Copy of My Records
⊗ Other (please describe, be specific) Insurance

INFORMATION WHICH MAY BE RELEASED:

I give **special authorization** to release information regarding:

☑ Psychiatric/Mental Health ☐ Substance Abuse ☐ HIV Information

Disclosure shall include the following types of information. Check all that apply.

☐ Evaluations/Assessments/Treatment Plans ☐ Lab Reports
☐ Inpatient Records ☐ Outpatient Records
☐ Drug Testing Results ☐ Crisis Records
☐ Financial Records ☐ Prescription/Medication Log
☐ ASAM Results
☐ Other (please be specific) _____

If special form is submitted for doctor to complete (please specify name of form) _____

EXCEPTION(S): Information That You Do Not Want Released (be specific):

I understand that such information cannot be released without my special consent, except when required by law and that all restrictions contained in this authorization as to use, transfer, or disclosure of such information apply to such records.
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to San Joaquin County Behavioral Health Services. I understand that the revocation will not apply to information that has already been released in response to this authorization.

DATE OF EXPIRATION (not to exceed one year from date of signature):_____

PROHIBITION ON USAGE, TRANSFER, OR REDISCLOSURE OF INFORMATION:
Except as required by state or federal laws, use of information released for other than the stated purpose or redisclosure or transfer of this information to any person or entity not named herein is prohibited. An additional written authorization must be obtained for any proposed new use of the information or its redisclosure or transfer of such information. Authorized information may be subject to redisclosure by the recipient and no longer protected by the privacy regulations.

RIGHT OF CLIENT TO RECEIVE A COPY OF AUTHORIZATION:
I understand that I have the right to receive a copy of this signed authorization.
I have received a copy of this authorization. ☐ Yes ☐ No

I understand that authorizing the use or disclosure of the information identified above is voluntary. San Joaquin County Behavioral Health Services will not condition treatment, payment, enrollment, or eligibility of benefits on whether I sign this authorization.

_____ Date_____
Signature of patient/client or legal representative*

*If signed by legal representative, authority/relationship to patient_____

Verification of client's ID at point of signature was completed and confirmed by my signature:

Witness (Staff name)_____

MINORS: By federal regulations in drug/alcohol abuse or HIV/AIDS related material then both the patient/client and parent, guardian or other person authorized to act by state law in his/her behalf is required.

NOTES: Where minor may consent to treatment by state law, only minor must sign.