Authorization to Exchange Protected Health Information

The information, as identified below, relates to the following client:

Name (*print first name, middle initial and last name*):	Date of Birth (*month/day/year*):

I hereby authorize:

Behavioral Health and Recovery Services – County of Marin		
Department of Health and Human Services	Telephone:	(415) 473-6835
250 Bon Air Road, Unit B, Greenbrae, CA 94904	Fax:	(415) 473-4113
Contact: Custodian of Medical Records		

To exchange information with:

Name of Agency, Individual, or Health Care Provider:		
Address:	City/State:	Zip Code:
Telephone Number:	Fax Number:	Contact Name (if known):

PURPOSE: The information may be used only for the following reason(s):

☐ For Continuity of Care
☐ For Treatment Planning/Case Management ☐ At the request of the client
☐ Other _____

INFORMATION: The following information is requested: *Important: Complete, initial, or sign and date as required.*

Records being requested:

_____

Records [Date(s)]: From _____ To _____

☐ ***Verbal Communication Only*** _____***(name and phone number)***

INFORMATION TO BE RELEASED: This is a full disclosure authorization of health care information which includes all medical, surgical, communicable diseases, and mental health records, , if any. This consent also authorizes the disclosure of HIV test results, if any. These records can be disclosed unless you specifically exclude below.

*Client **Excludes** the release of the following information*:
Please initial which information you **DO NOT** want released:

Exclude Mental Health Treatment _____ (Initial/date)
Exclude Results of an HIV Test _____ (Initial/date)
Exclude Other_____ _____ (Initial/date)

Client Name (print first name, middle initial, last name):	Date of Birth (*month/day/year*):

RE-USE OF INFORMATION: I understand that if I authorize the release of my health information to someone who is not legally required to keep it confidential, that information may be shared with others and may no longer be protected. I understand that health and mental health information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

CONDITIONS: I understand that I do not have to sign this Authorization form. I understand that treatment, payment, enrollment and eligibility for benefits will not be based on my signing or refusing to sign this authorization. I understand however, that refusal to authorize specific disclosures can affect my ability to participate in certain programs. I have a right to receive a copy of this authorization.

RIGHT TO TAKE BACK AUTHORIZATION: I understand that I have the right to take back my authorization. If I take back my authorization, I have to notify the County in writing at the following address**:**

Behavioral Health and Recovery Services,
Department of Health and Human Services,
250 Bon Air Road, Unit B.
Greenbrae, CA 94904.
Attention: Custodian of Medical Records

My revocation will take effect upon receipt, except to the extent that others have acted in reliance on this authorization.

EXPIRATION: This authorization will go into effect immediately and will remain in effect until _____ (write in date). If I do not write in a date, this authorization will remain in effect for one year from the date of my signature.

Signature (*Client or Representative, as appropriate*)*:	Date (*month/day/year*):
** If form is signed by someone other than the client, state the relationship to client,* Name (*print*): _____ Relationship: _____	
Name of County Representative Who Receives this Form *(Print)*:	Date (*month/day/year*):