

**County of Butte - Authorization for Use or Disclosure of Health Information**

**CLIENT INFORMATION**

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS	CITY/STATE/ZIP CODE:	DATE OF BIRTH:
CLIENT'S PHONE NUMBER	CLIENT FILE/CASE NUMBER	

**AUTHORIZATION DETAILS**

**Records Coming From (Disclosed by):** Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to make use of and/or disclose the information described in this form.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Records Going To (Received by):** Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to receive the information described in this form.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PURPOSE OF DISCLOSURE OF PHI**

- Treatment and treatment-related activities (to assess, coordinate, provide, or refer to others, for treatment)
- Case Management /Oversight (to other agencies and providers for services other than treatment)
- Payment, billing, insurance claim, eligibility for public/private benefits
- At the request of the individual/client                       At the request of an authorized representative
- OTHER: \_\_\_\_\_

**SERVICE DATES**

The information to be used or disclosed includes only those items checked above, with respect to services provided on or around: \_\_\_\_\_ (insert dates of service). **NOTE:** If this section is left blank, the treatment dates covered by this authorization are from the most recent date of service (or course of treatment) and claims resolution.

**EXPIRATION OF AUTHORIZATION**

**THIS AUTHORIZATION SHALL BECOME VALID IMMEDIATELY AND SHALL REMAIN IN EFFECT FOR THE FOLLOWING PERIOD: (The Client/Patient MUST INITIAL one of the following for the authorization to become valid.)**

- \_\_\_\_\_ This authorization expires one year from the signature date below.
- \_\_\_\_\_ This authorization expires as specified: \_\_\_\_\_
- \_\_\_\_\_ This authorization expires once information is disclosed. This is a one-time authorization.

**TYPE OF INFORMATION TO BE USED OR DISCLOSED**

I understand that this authorization extends to all or any part of the records/information designated below, which may include treatment for mental illness and/or alcohol/drug abuse. The information to be used or disclosed includes: **(The client MUST INITIAL items being requested)**

- Assessment/History  Treatment Records  
 Medication Records  Lab Reports  
 Inpatient Records  Intake/Admission Summary  Medical Finding  
 Progress Notes: (specify) \_\_\_\_\_  
 Billing Records  Financial Records:(specify) \_\_\_\_\_  
 Public Social Services Records (Welfare and Related Social Programs Information)  
 Discharge Summary  
 OTHER (please specify): \_\_\_\_\_

**I UNDERSTAND THAT THE INFORMATION TO BE DISCLOSED WILL INCLUDE: (Client MUST INITIAL)**

- Alcohol/Drug Records OR  Do Not Disclose  
 Attendance Only OR  Do Not Disclose  
 Mental Health Records OR  Do Not Disclose  
 HIV Test Results OR  Do Not Disclose

This authorization is limited to only that information that I have requested above to be used or disclosed to the persons/facilities named herein. I hereby release the County of Butte from all legal responsibilities or liability that may arise from the use or disclosure of information in reliance on this authorization.

**NOTICE TO RECIPIENT OF PHI**

Please note Federal Confidentiality Rules (42 CFR Part 2) and California Law prohibit further disclosure of medical and/or mental health records, unless further use or disclosure is expressly permitted by obtaining a written authorization for disclosure of information from the person to whom it pertains. A general authorization for the use or disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

**CLIENT RIGHTS & RESPONSIBILITIES**

- 1. Re-Disclosure under HIPAA:** I understand that information used or disclosed in accordance with this authorization may no longer be protected by the Health Insurance Portability & Accountability Act of 1996 (HIPAA), and could be used or re-disclosed by the receiving party. However, as noted above, federal and state regulations governing the confidentiality of alcohol and drug abuse patient records will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from re-disclosure.
- 2. Revocation:** I have the right to make a written request to stop the use or disclosure of information at any time although I understand that I cannot do anything about information already used or disclosed under this authorization.

- 3. **Refusal to sign:** I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits except as may be permitted by law.
- 4. **Copy:** I understand that I will receive a copy of this authorization free of charge. However, for requests for other file copies, a fee may apply.
- 5. **Minors:** I understand that minors 12 years of age and older may be required to sign the authorization along with their parent/guardian.

**SIGNATURE**

Client Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

If Applicable:

Parent/Guardian/Authorized Representative Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Complete Address: \_\_\_\_\_  
*Street Address City State Zip Code*

Relationship to Client \_\_\_\_\_

**COPY:** ( ) Given to client at time of signature; ( ) Given to client on \_\_\_\_\_ ( ) Mailed to client on \_\_\_\_\_ ( ); ( ) Copy Refused by Client \_\_\_\_\_ (initial and date) Filed on \_\_\_\_\_.

**REVOCAION OF AUTHORIZATION**

As of this date, \_\_\_\_\_, I hereby revoke this authorization.

\_\_\_\_\_  
Name of Client

\_\_\_\_\_  
Signature of Client Revoking Authorization

If Applicable:

\_\_\_\_\_  
Name of Parent/Guardian

\_\_\_\_\_  
Signature of Parent/Guardian Revoking Authorization

**STAFF VERIFICATION**

(FOR INTERNAL USE ONLY)

- I have verified the client's signature against the medical record.
- I have relied on the following identification: \_\_\_\_\_
- Known to County Staff by:  Prior verification;  Other: specify \_\_\_\_\_
- I have received \_\_\_\_\_ as documentation that verifies the representative's relationship with the client and the authority to request/receive health information on behalf of the client.

Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Staff Name: \_\_\_\_\_