Attachment A
Shasta County Health and Human Services Agency (HHSA)
Authorization to Use or Disclose Protected Health Information

This is an attachment to authorize additional persons and/or organizations to receive the health information described in the Authorization for Use or Disclosure of Information executed by (or on the behalf of): Last Name: _____ First Name: _____ Middle Initial: ___

Date of Authorization: _____ Date of Birth: _____ Chart #: _____

The following person(s) and/or entity(ies) are hereby incorporated into the above-described Authorization:

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

SIGNATURE OF CLIENT OR LEGAL REPRESENTATIVE

Signature: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

If signed by legal representative, relationship to Client: _____