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

Failure to provide all information requested may invalidate this authorization. I hereby authorize use or disclosure of the named individual's health information as described below. I understand this release may include the disclosure or exchange of information in written, verbal, electronic, and/or other forms.

Client Information:

Last Name: _____ First Name: _____ Middle Initial: ____

Address: _____

City: _____ State: ____ Zip: _____

Telephone Number: _____ Date of Birth: _____

Initial each item of information to be disclosed.

In addition to general medical, I specifically authorize the following release:

___ **Mental Health**	___ **Alcohol & Drug**	___ **Behavioral Health Team**
___ **Public Health**	___ **HIV**	___ **Women's Recovery & Resiliency Services**

Purpose/Limitation of requested use or disclosure (check one):

☐ Client Request ☐ Evaluation ☐ Continued Care Treatment ☐ Litigation

☐ Limitation/Other: _____

The following person or entity is authorized to make the disclosure:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

This information may be disclosed to:

Note: If Attachment A is included, **INITIAL** here _____, to authorize additional individuals or entities:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

Rights, Expiration and Notice of Potential Re-Disclosure:

I understand I have the right to revoke this authorization. I understand if I revoke this authorization I may do so in writing and submit it to the following address, or I may request assistance where I receive services:

I understand the revocation will not apply to information already released based on this authorization. If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be re-disclosed and no longer protected, but any alcohol and/or drug treatment records cannot be re-disclosed without my written consent unless otherwise provided for by 42 CFR Part 2 and 45 CFR parts 160 and 164. I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment or payment, enrollment, or eligibility for benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed. I have the right to receive a copy of this authorization.

Expiration: Unless otherwise stated, this authorization expires one year from the date of signature.

Desired alternate/meaningful date of expiration: _____

Signature of Client or Legal Representative

I hereby authorize the use and disclosure of my information in accordance with the information entered above for the purposes described in this form. I understand this does not authorize the recipient of this disclosed information to further use or disclose this information, except as allowed or required by law. I further understand information released then becomes the responsibility of the recipient and is no longer under the protection of the releasing entity.

Signature: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

If signed by legal representative, relationship to Client: _____

This space for use by Shasta County Staff only

Staff Member Initiating Request: _____ Date: _____

Staff Member Completing Request: _____ Date: _____

Chart #: _____

- ☐ Fax
- ☐ File
- ☐ Mail
- ☐ Transmit