**Shasta County Health and Human Services Agency**

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH**

**INFORMATION**

**Form Instructions**

**IMPORTANT: Do not alter the authorization form.**

**To protect client confidentiality, do not electronically save a copy of the authorization form.**

The Health and Human Services Agency, *Authorization to Use or Disclose Protected Health*

*Information* form grants permission for us to share or receive information about the client with other individuals or entities.

The form contains drop-down menus. Should the entity or individual not be listed on the drop-down menu, you may type in your selection. When completing this form, be sure to provide all requested information. Failure to provide all requested information may invalidate the form.

This form may be completed electronically, printed, then appropriately initialed and signed by the client.

**CLIENT INFORMATION:**

This section names the client whose health information we are being authorized to release receive, as well as the type of information to be disclosed. Each type of information authorized for disclosure must be **initialed** by the client or their personal representative after the form is printed.

Be aware information contained in an Alcohol and Drug chart originating from another individual or entity **cannot** be re-disclosed. The client must specifically authorize the release of any mental health, alcohol and drug, and/or HIV information by initialing the appropriate area on the form.

**PURPOSE/LIMITATION OF REQUESTED USE OR DISCLOSURE:**

Choose the appropriate purpose. If the purpose for the disclosure is not one of the four listed, the client, guardian or personal representative may check the "other" box and specify the purpose. The client, guardian, or personal representative may also set a limitation by entering it in the space provided, for example, “verbal communication only.”

**BIDIRECTIONAL EXCHANGE OF PROTECTED HEALTH INFORMATION:**

This form allows the bidirectional exchange of protected health information by selecting or writing in “See Attachment A incorporated herein by reference” on **both** “The following person or entity is authorized to make the disclosure,” and the “This information may be disclosed to” selection boxes.

**THE FOLLOWING PERSON OR ENTITY IS AUTHORIZED TO MAKE THE DISCLOSURE:**

This section names the individual or entity authorized to release the information. To authorize more than one individual or entity, choose “See Attachment A incorporated herein by reference.”

**THIS INFORMATION MAY BE DISCLOSED TO:**

This section names the individual or entity authorized to receive the information.

Choose “See Attachment A incorporated herein by reference,” if you are using Attachment A. Attachment A should be completed if the information is to be received or released by more than one individual or entity. When selecting from the drop-down menu, read the selections carefully to ensure you are choosing the correct individual or entity and the correct address. If the individual or entity is not listed or the address is out of date, type the information in the space provided.

**RIGHTS, EXPIRATION AND NOTICE OF POTENTIAL RE-DISCLOSURE:**

**Right to Revoke:** Choose from the drop down or type in the appropriate address where the records are held.

**Expiration:** The form will expire one (1) year from the date of signature unless an alternate, meaningful date of expiration is entered. A meaningful date could be the completion of the Addicted Offender Program or a minor’s 18th birthday. This date may be greater or less than one year from the date of signing.

**SIGNATURE OF CLIENT OR LEGAL REPRESENTATIVE:**

Enter a date into the date field, or leave it blank for the client to date by hand at the time of signing. Once the date and legal representative information is entered, the form is ready to be printed, initialed, and signed by the individual authorized to request the information.

If the client is age 12 or over, they *must* sign the authorization form for all outpatient mental health or other minor consent services, unless a clinician has indicated in their chart the client does not have the capacity to sign. The Parent or Guardian may also sign on the additional line for the Parent or Guardian. If a judge has given a social worker signing authority for a ward or dependent of the court, the social worker may sign the authorization for minors under the age of 12. You must include a copy of the most recent signed court order with the authorization if a judge has ordered signing authority to another individual or entity. Since the Parent, Guardian, or personal representative must authorize mental health medications for all minors, medication consents or releases are never minor consent. The Parent, Guardian, or whomever has signing authority, must authorize the release of medication consents.

If a client is conserved, please attached a copy of the signed conservation orders. A conserved client does not have signing authority. The conservator or Public Guardian is required to sign.

**THIS SPACE FOR USE BY SHASTA COUNTY STAFF ONLY**

**Staff Member Initiating Request:** This is the County staff member initiating the authorization form. Staff should print their name and date. If there are questions about the form, or it needs to be returned, this helps Medical Records staff identify the staff member.

**Staff Member Completing Request:** This is the County staff member assisting the individual or entity in completing this form by faxing, filing, mailing, or transmitting the information as requested. Staff should print their name and date.

**FAX/FILE/MAIL/TRANSMIT:**

**Fax:** Staff should complete the request by faxing the documents to the appropriate party.

**File:** No action is required other than to file the form in the client’s chart.

**Mail:** Staff should complete the request by mailing the documents to the appropriate party.

**Transmit:** Staff should complete the request by transmitting the documents to the appropriate party by other means, usually provided by the other party (i.e. secure file transfer protocol). Typically, your medical records staff will perform these duties.

**ATTACHMENT A**

Complete Attachment A to authorize disclosure from or to more than one individual or entity. Up to 13 different individuals or entities may be entered per Attachment A. If more than 13 are needed, complete an additional Attachment A and update the page number in the lower right-hand corner. The client information entered on Attachment A must match the client information entered on page one of the authorization form. When making a selection(s) from the drop-down menu, read the selection carefully to ensure you are choosing the correct individual or entity with the correct address. If the individual or entity is not listed or the address is not correct, type the information in the spaces provided.

**SIGNATURE OF CLIENT OR LEGAL REPRESENTATIVE: (Attachment A)**

Enter a date into the date field, or leave it blank for the client to date by hand at the time of signing. . A different date may be entered. Once Attachment A is completed the form is ready to be printed, initialed, and signed by the individual authorized to request the information. Attachment A must be attached to the initial authorization form.

\*Only the current version of the Authorization to Use or Disclose Protected Health Information form is acceptable. Previous versions are invalid. The current versions may always be found on the [Privacy and Security Intranet Page](http://intranet/hhsa/privacy-security) or on the [Privacy and Security Page on the Internet](https://www.co.shasta.ca.us/index/hhsa_index/hipaa.aspx), under the *Forms* section. If you are using these forms on any of your webpages, link directly to the documents on the Privacy and Security Page.