

**AUTHORIZATION FOR RELEASE
OF PATIENT INFORMATION**
MH 5671 (Rev. 08/04) Page 1 of 3

Confidential Patient Information
See W&I Code Section 5328 and
HIPAA Privacy Rule CFR Section 164.508

INSTRUCTIONS: Use this form to obtain the required authorization when a request is received for patient information, unless the request received is a facsimile of this form or contains all of the required information. Obtain signature of patient or parent/guardian/conservator. If patient signs, obtain "witness signature." List the information released per this authorization on the back of this form.

The hospital shall not condition treatment or payment based on this authorization. The patient may refuse to sign the authorization. If the authorization is not signed, the information shall not be released except when required by law. Upon request, the patient may inspect or be provided a copy of the protected health information to be disclosed by this authorization.

Patient's Name _____ Birth Date _____
Month Day Year

I, _____ and/or _____
Name of Patient Name of Parent/Guardian/Conservator

hereby authorize _____
Name of Agency/Person/Organization

Address (Street, City, State and Zip Code)

to release to _____

the information specified on Page 2 of this form with the knowledge that such release discloses the fact that mental health services have been/are being provided.

Large empty rectangular area for signature or additional information.

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This disclosure of information* is required for the following purpose(s): (initial applicable areas)

- Evaluation Treatment Planning/Course Other (Specify) _____

and shall be limited to releasing the following types of information (initial all applicable areas): from (date required) _____ to (date required) _____ ; or any information/records indicated, regardless of date.

- | | | |
|--|---|--|
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Seclusion and/Restraint Information | <input type="checkbox"/> Results of Psychological/Vocational Testing |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> HIV Tests Results | <input type="checkbox"/> Conference(s) Date(s) |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Other Evaluations/ Assessments (specify) | _____ |
| <input type="checkbox"/> Discharge Summary | _____ | _____ |
| <input type="checkbox"/> Social History | _____ | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Individual Treatment Plan | _____ | _____ |
| <input type="checkbox"/> Legal Information | _____ | _____ |
| <input type="checkbox"/> Medical, Neurological Assessment, Lab Tests, e.g., EEG, EKG, etc. | _____ | _____ |

*The information disclosure under this authorization may be subject to re-disclosure by the recipient if allowed or required by law. This authorization becomes effective (Month/Day/Year) _____. This authorization may be revoked in writing by the undersigned at anytime except to the extent that action has already been taken. If not revoked, it shall terminate at the end of (check one):

- 6 months One year or Specify Date _____

I understand that I am to receive a copy of this authorization.

_____ Signature of Patient	Date: _____ Month Day Year
_____ Parent/Guardian/Conservator, if Applicable	Date: _____ Month Day Year
_____ Witness Signature	Date: _____ Month Day Year
_____ Signature of Professional*	Date: _____ Month Day Year

Signature of Professional* Date _____
Person Obtaining Authorization Date

*Professional for this authorization refers only to a physician, licensed psychologist or social worker with a master's degree in social work who approves this patient initiated request for release of patient records.

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RECORD OF RELEASE OF INFORMATION

The following information was released to the named party specified on the front of this form. Identify the specific dates of the reports, records, items released.

- | | | |
|---|---|--|
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Legal Information | <input type="checkbox"/> Other Evaluations/
Assessments (specify) |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Medical, Neurological
Assessment, Lab
Tests, e.g., EEG,
EKG, etc. | _____ |
| <input type="checkbox"/> Psychiatric Evaluation | | _____ |
| <input type="checkbox"/> Discharge Summary | | _____ |
| <input type="checkbox"/> Social History | <input type="checkbox"/> HIV Tests Results | <input type="checkbox"/> Conference(s) Date(s) |
| <input type="checkbox"/> Individual Treatment
Plan | <input type="checkbox"/> Results of Psychological/
Vocational Testing | _____ |
| <input type="checkbox"/> Other: | | _____ |

Released By (Name & Title)

Date Released