Alameda County Behavioral Health Care Services
2000 Embarcadero Cove, Suite 400 Oakland, California 94606

AUTHORIZATION TO DISCLOSE INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI)

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial**

Date of Birth | **Social Security No.** | **Home Phone** | **Work Phone** | **Extension**

Street Address | **City** | **State** | **Zip Code**

I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION BE RELEASED FROM:

Physician Name / Clinic / Hospital / Other | **Phone Number** | **Extension**

Street Address | **City** | **State** | **Zip Code**

I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION BE RELEASED TO:

Physician Name / Clinic / Hospital / Other | **Phone Number** | **Extension**

Street Address | **City** | **State** | **Zip Code**

INFORMATION REQUESTED

For Dates of Service from _____ **through** _____

(☐) Entire Record	(☐) X-Ray Reports	(☐) Psychiatric Assessment
(☐) Record Notes	(☐) Laboratory Reports	(☐) Psychosocial Evaluation
(☐) Medical History	(☐) HIV Information	(☐) Psychological Testing
(☐) Discharge Summary	(☐) Drug/Alcohol Treatment	(☐) Psychiatric Information (General)

(☐) Other _____

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I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization and that I am entitled to receive a copy of this authorization and want and have received such a copy. ☐ Yes ☐ No

EXPIRATION: This Authorization expires twelve (12) months from: (☐) _____
(☐) the date signed

PURPOSE OF TRANSFER OF RECORDS

(☐) Permanent Transfer (☐)Referral (☐) Other:

(☐) Patient
(☐) Parent
Signature (☐) Guardian Date

Some types of information require a specific authorization to be released because of federal or state laws. They are identified below. By signing, I specifically authorize the release of the following confidential information: Please check the appropriate box or boxes:

(☐) Mental Health Records (☐) HIV Test and Test Results
(☐) Psychotherapy Notes (☐) Drug/Alcohol Program Records*

_____ _____
Signature of Patient, Parent, or Guardian Date If required, additional signature* Date

*MINORS: If a minor aged 12-18 has consented to the Drug/Alcohol Abuse Program treatment, as permitted under California law, ONLY the minor's signature should be obtained. If the parent/guardian's consent was required for the treatment of the minor, Federal regulations applicable to Drug/Alcohol Abuse Program records require the signature of BOTH the patient and the parent, guardian, or other person authorized to act by State law in his/her behalf.

REVOCATION: I understand that I have a right to revoke this information at any time unless prior action has been taken in response to this authorization. I understand that my revocation must be in writing and presented to an ACBHCS Health Information representative.

WARNING: PROHIBITIONS ON USAGE, TRANSFER OR REDISCLOSURE OF INFORMATION, except as required by State or Federal laws, use of information released for other than the stated purpose, or redisclosure or transfer of this information to any person or entity not named herein is PROHIBITED. An additional written authorization must be obtained for any proposed new use of the information or for its redisclosure or transfer of such information.

MEDICAL RECORDS WILL BE RETAINED FOR SEVEN (7) YEARS FOLLOWING A PATIENT'S DISCHARGE FROM OUR AGENCY, WHEREUPON THEY WILL EITHER BE DESTROYED OR, IF REQUESTED, RETURNED.