San Diego

SAN DIEGO YOUTH & COMMUNITY SERVICES
EVERY CHILD DESERVES A CHANCE

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information

Service Partner's Full Name	Birthdate	Phone Number
_____	_____	_____

do hereby authorize the exchange and/or release of information and/or records

between: _____ and: _____

_____ _____

I understand that the information and/or records to be released may contain information pertaining to: school records, physical health, psychiatric/mental health, individual, family, group counseling, case-management, legal/probation background, financial records, housing and rental history, and/or alcohol and other drug treatment. I further understand that this information shall be released in accordance with all state and federal laws including Title 42, Code of Federal Regulations, Part 2.

The disclosure of information and records authorized herein is required for the following purposes:

_____

The following information is to be released:

__ History and Physical Examination
__ Discharge Summary
__ Progress Notes
__ Medication Records
__ Laboratory Results
__ Dental Records
__ Psychiatric records
__ School Records
__ Physician Orders
__ Pharmacy Records
__ Immunization Records
__ Billing Records
__ Drug/Alcohol Rehab. Records
__ Complete Record
__ Other _____

I specifically request that the following information <u>not</u> be released:

_____

_____

I may revoke this authorization at any time before the information has been released. I understand that I must submit this revocation in writing and that it must contain the following information:

- Service Partner name and address

- Effective date of this authorization and the recipient of the information according to this authorization
- Service Partner's desire to revoke the authorization
- The date of the revocation and the Service Partner's (if minor child and no minor consent, parent/guardian or legal representative) signature.

Unless otherwise revoked, this authorization will expire in:

___ six months ___ one year ___ other

_____ (Initial) I have been provided with a copy of this authorization.

_____ (Initial) I have been provided a copy of this authorization and given the opportunity to review it, but I have declined to take a copy of the authorization.

I agree that a signed photocopy or fax of this authorization is to be considered as effective as the original.

I have read this authorization and understand what information will be used or disclosed, who may use or disclose the information and the recipient(s) of that information. I understand that if I have authorized the release of information to someone who is not legally required to keep it confidential, the information may be re-disclosed and no longer protected. California law generally prohibits recipients of my health information from re-disclosing such information except with my written authorization or as specifically required or permitted by law.

I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. SDYCS shall not condition treatment upon the signing of this authorization.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section 164.524.

_____ _____
Service Partner Signature Date

_____ _____
Parent, Guardian, or Authorized Representative Signature Date

_____ _____
Parent, Guardian, or Authorized Representative Signature Date

_____ _____
Staff Signature Date