TULARE COUNTY
HEALTH & HUMAN SERVICES AGENCY
Cheryl L. Duerksen, Ph.D., Agency Director
MENTAL HEALTH DEPARTMENT • TIMOTHY D. DURICK, PSYD • DIRECTOR

# AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

CONSUMER'S NAME: _____ BIRTH DATE: _____

**INFORMATION TO BE RELEASED TO:**

NAME/AGENCY: Tulare County Probation

ADDRESS: 11200 Ave 368, Visalia CA. 93291

PHONE: (559) 735-1600 FAX (559) 713-3046

**INFORMATION TO BE RELEASED FROM:**

NAME/AGENCY: Criminal Justice Mental Health

ADDRESS: 11200 Ave. 368, Visalia CA. 93291

PHONE: (559) 713-1350 FAX (559) 713-3296

**PURPOSE AND LIMITATIONS FOR RELEASE:**
Attendance, participation, and treatment

**INFORMATION TO BE RELEASED:**

- ☐ Intake Assessment
- ☐ Lab Reports
- ☐ Treatment Plans
- ☐ Psychiatric Evaluations
- ☐ Consultation Reports
- ☒ Physician's Orders
- ☐ Progress Notes
- ☐ Psychological Test/Evaluation Results
- ☐ Diagnoses (Medical)
- ☐ Discharge Summary
- ☒ Diagnoses (Psychiatric)

**Other (Specify):**
To share information with Tulare County Probation regarding minor's mental health treatment.

| Date: | Consumer's Name: | | CMHC #: | |
|---|---|---|---|---|
| Service | | Location | Time | |

This authorization is effective immediately and is subject to revocation at any time, except to the extent that action has already been taken. Otherwise, this authorization expires on_____. I am aware of and have been advised of the provisions of existing Federal **[Health Insurance Portability and Accountability Act (HIPAA)]** and State Statutes, Rules and Regulations, **as outlined on page 3 of this form,** which provide for my right to confidentiality of the information in these records.

I realize that this is a required authorization and that I must voluntarily and knowingly sign this authorization before any records can be released, and that I may refuse to sign, but in that event the records cannot and will not be released.

**Patient Initials _____**

I further release my attending physician, the clinic/hospital and employees of the clinic/hospital, school and employee from any liability arising from the release of information to the person(s)/agency designated above. **A PHOTOCOPY/FAX OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.**

_____ has the right to receive a true copy of this authorization
(NAME OF CONSUMER/GUARDIAN) by placing initials _____ to the left of this clause on the original authorization. (HIS OR HER)

_____ acknowledges that a true copy of this authorization and
(NAME OF CONSUMER) the separate "Information For Authorization" has been received.

SIGNATURE OF CONSUMER DATE

SIGNATURE OF PARENT/GUARDIAN/REP (when applicable) DATE

RELATIONSHIP TO CONSUMER: _____

| Date: | Consumer's Name: | | CMHC #: | |
|---|---|---|---|---|
| Service | | Location | Time | |

# INFORMATION FOR AUTHORIZATION

The privacy and confidentiality of medical, psychiatric and substance abuse information is protected by Federal and State Statutes, Rules and Regulations (including: Health Insurance Portability and Accountability Act, Standards for Privacy of Individually Identifiable Health Information – 45 CFR Parts 160 through 164, California Confidentiality of Medical Information Act; California Administrative Code, Title 22; California Civil Code section 56 et seq. California Welfare and Institutions Code, section 5328; and Title 42 of the Code of Federal Regulations). These Statutes, Rules and Regulations require that the client give informed consent prior to the release of any health/hospital records or information, except as specifically provided for within the Statutes, Rules and Regulations.

California Civil code section 56.11: An authorization to release health/hospital information will be considered valid only when it state: (1) who will release the information; (2) who will receive the information; (3) the purpose and limitations for which the information will be used; (4) what specific information will be released; and (5) when the authorization will expire. The authorization must also contain the client'/authorized representative's signature and the date of the signature. This Authorization of the Release of Protected Health Information waives any and all rights that the patient now has or may in the future have to bring any legal action against the releasing person/facility for any damages caused directly or indirectly by the release of this information or other confidential information. The authorization must be completely filled out and cannot be missing any required elements.

A minor client may only sign an authorization for the release of their health/hospital information for services, which the minor could lawfully consent. The authorization of their parent or authorized representative is needed for the release of their health/hospital information for services, which the minor could not lawfully consent. The signature of the authorized representative is required for patients who are conservatees under the Probate Code. Authorized representatives signing for the client must submit copies of the legal documents supporting the assignment of this authority.

Upon request, you will be furnished with a copy of the complete "Authorization for the Release of Protected Health Information" and "Notice of Health and/or Mental Health Information Practices".

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations."

| Date: | Consumer's Name: | | CMHC #: | |
|---|---|---|---|---|
| Service | | Location | Time | |