Didi Hirsch
MENTAL HEALTH SERVICES

AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED INFORMATION

Completion of this form authorizes the disclosure of your Protected Health Information (PHI) and school information as described below which consistent with federal (1) and state laws (2) concerning the privacy of such information and cannot be disclosed without your written authorization. All items must be completed in order for the authorization to be valid.

I understand that Didi Hirsch may deny this request under limited circumstances as provided for under federal and California law protecting the privacy of health information. I further understand that, except as permitted under the law, I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by Didi Hirsch who did not participate in the agency's decision to deny my request.

I understand that Didi Hirsch MHS will notify me of its decision to approve or deny access within five (5) working days of their receiving my written request. I understand that if my request for information is approved, a copy will be made available to me within ten (10) working days of approval.

I understand that if I request a summary of my health information, I will be able to inspect or obtain a copy of the summary within ten (10) working days from the date of receipt of my request. If Didi Hirsch needs additional time to prepare the summary because of the length of the record or because the client was discharged from Didi Hirsch within ten (10) days prior to receipt of my request,
I will be notified and the agency may have up to thirty (30) days from the date of receipt of my request to make the summary available to me.

Please provide us with the following information so that we can best serve you.

Are you currently a client? ☐ **Yes** ☐ **No**

Client: _____ _____ _____
Name of Client / Previous Names | Birth Date | DMH IBHIS ID#

_____ _____
Street Address | City, State, Zip

AUTHORIZES THE RELEASE OF PROTECTED INFORMATION **FROM:**	PROTECTED INFORMATION BEING RELEASED **TO:**
Name of Person / Agency	Name of Person / Agency
Name of Contact Person	Name of Contact Person
Street Address	Street Address
City, State, Zip	City, State, Zip
Phone / FAX Number	Phone / FAX Number

☐ **Check this box only if you are authorizing bi-directional transfer of information between the two entities listed above.**

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INFORMATION TO BE RELEASED: (check all that apply)

(I specifically authorize Didi Hirsch to disclose the following types of PHI)

- ☐ Progress Notes
- ☐ Summary of Services Received
- ☐ Treatment Plan
- ☐ Discharge Information
- ☐ Medical Diagnoses/Conditions, including ICD Codes
- ☐ Labs/Test Results (For Date Range: _____)
- ☐ Attendance Information
- ☐ Description of behavior and/or behavioral checklists
- ☐ Psychological Testing- Summary
- ☐ Psychological Testing Report-Copy
- ☐ Scholastic Capability
- ☐ Medication History/Current Medications

☐ Other (Specify): _____

_____

Date Range of Records to Release from: ___/___/_____ to ___/___/_____

SPECIFIC AUTHORIZATIONS:

The following information will not be released unless you specifically authorize it by checking and initialing the relevant box(es) below.

_____ I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment **42.C.F.R§§2.34 and 2.35.**

_____ I specifically authorize the release of HIV/AIDS testing information.
Must obtain witness signature when authorizing release of HIV/AIDS information. A new authorization must be obtained for each additional use or disclosure of an HIV/AIDS information. **Cal. Health & Safety Code § 120980 (g).**

PURPOSE OF DISCLOSURE: ☐ Legal ☐ Treatment Planning ☐ Personal ☐ Request for Form Completion
Other (Specify): _____

EXPIRATION DATE: This authorization is valid from: ___/___/_____ to ___/___/_____
Not to exceed 1 year from date signed

Client's Initials: _____

RESTRICTIONS

I understand that California law and federal law prohibits the person disclosing this information from making further disclosure of my health information unless that person obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS WITH RESPECTS TO THIS AUTHORIZATION:

Right to receive a signed copy of this Authorization.

Right to Revoke this Authorization. I may use the Revocation of Authorization at the bottom of this form, or my Revocation must be in writing, signed by me or on my behalf, and **delivered to my service provider.** My revocation will be effective upon receipt, but will not be effective to the extent that the requestor has already used my information.

Conditions: I understand that Didi Hirsch MHS may not condition my treatment, payment, enrollment or eligibility for benefits on my providing or refusing to provide this information. However, in certain circumstances I may be denied

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treatment if I do not provide or refuse to provide this information. (In other words, if this authorization is related to research that includes treatment, you will not receive that treatment unless this authorization form is signed.)

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

I would prefer to have the requested records sent via:

☐ Encrypted Email ☐ Mail ☐ Fax

☐ Pick-up ☐ Other Electronic Method (e.g Client Portal

☐ Other: Please Specify

_____ _____
Signature of Client Date

Client Name (print): _____

_____ _____
Signature of Legal Representative Date

Name of Legal Representative_____

If signed by someone other than the client, state relationship to the client:_____

Providers do not have the right to disclose medical records to parents without the minor's consent (12 years+). The provider can only share the minor's medical records with a signed authorization from the minor. (Cal. Heath & Saf. Code12311 (a),123115(a)(1);Cal. Civ. Code 56.10,56.11,56.30; Cal. Welf.& Inst.Code5328

_____ _____
Witness Signature / Print Name: Date
(Witness Signature required ONLY if releasing HIV/AIDS information.)

This Authorization was translated into _____ for the client.

REVOCATION OF AUTHORIZATION

SIGNATURE OF CLIENT/LEGAL REP: _____
If signed by other than client, state relationship and authority to do so:
Date: ___/___/____

[1]Health Insurance Portability and Accountability Act of 1996 ("HIPAA") (45 CFR Pts. 160 and 164)
[1]Family Education Rights and Privacy Act of 1974 (FERPA) Federal Regulation (20 U.S.C. § 1232g; 34 CFR §99)
[2]California Welfare and Institutions Code Section 5328

☐ **Client was provided a copy of this Request for records**