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.

Client: _____ _____ _____

Name of Client / Previous Names | Birth Date | DMH 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.**

INFORMATION TO BE RELEASED: (check all that apply)

☐ Summary of Services Received
☐ Treatment Plan
☐ Discharge Information
☐ Imaging Studies
☐ Medication History/Current Medications
☐ Medical Diagnoses/Conditions, including ICD Codes
☐ Labs/Test Results (For Date Range: _____)
☐ Psychological Testing Report-Copy
☐ Psychological Testing- Summary
☐ Description of behavior and/or behavioral checklists
☐ Report Cards(s)
☐ Copies of Individual Educations Plans (IEP's)
☐ Suspensions, expulsions, and school attendance review board (SARB) information
☐ Scholastic Capability
☐ Attendance Information
☐ Employment Verification
☐ 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. Due to COVID-19 crisis, client provided verbal authorization for release of drug and alcohol abuse diagnosis or treatment information, reflected in a checked box only.

☐ _____ I specifically authorize the release of HIV/AIDS testing information Cal. Health & Safety Code § 120980 (g). Due to COVID-19 crisis, client provided verbal authorization for release of HIV/AIDS testing information, reflected in a checked box only.

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PURPOSE OF DISCLOSURE: ☐ Coordinating Service ☐ Client's Request ☐ Treatment Planning
Other (Specify): _____

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

Client's Initials: _____

☐ **Client provided verbal authorization due to COVID-19 crisis, reflected in a checked box only.**

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 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.

_____ _____
Signature of Client / Personal Representative Date

Client Name (print): _____

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

☐ **This request for PHI was received in a non-standard manner due to COVID-19 crisis. Client/caregiver provided verbal consent/authorization for this request of protected information. Client/caregiver unable to sign due to recommendations from Public Health agencies regarding face to face related contact related to COVID-19. Checked box reflects client's authorization for this request.**

_____ _____
Witness Signature / Print Name: Date

This Authorization was translated into _____ for the client.

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REVOCATION OF AUTHORIZATION

SIGNATURE OF CLIENT/LEGAL REP: _____

If signed by other than client, state relationship and authority to do so:

☐ Revocation of Authorization requested by client/legal rep/caregiver verbally due to COVID-19 crisis, reflected in checked box. Client/legal rep/caregiver unable to sign due to recommendations from Public Health agencies regarding face to face related contact related to COVID-19.

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