Lassen County Collaborative Inter-Agency Authorization to Release, Use, Disclose and Exchange, Verbal and Written Protected Health Information

The information, as identified below, relates to the following client:

Name (print first name, middle initial and last name):	Date of Birth (m/d/y):

Authorization: I give permission to:

Name of Agency, Individual or Health Care, Provider:		
Address:	City/State:	Zip Code:
Telephone Number:	Fax Number:	Contact Name:

To release information to:

Name of Agency, Individual or Health Care, Provider:		
Address:	City/State:	Zip Code:
Telephone Number:	Fax Number:	Contact Name:

And/or to exchange information with:

(If all agencies listed below may share your information, **Initial** here _____)
(Initial those agencies with which you authorize information sharing)

Lassen County:

____ Behavioral Health Mental Health Services
____ Behavioral Health Substance Use Disorder Services
____ Child & Family Services
____ Health and Social Services Administration
____ Lassen WORKS (Welfare)
____ Patients' Rights Advocate
____ Probation Department
____ Public Health

____ Northeastern Rural Health Clinic
____ Head Start
____ Lassen County Office of Education
____ Pathways
____ Family Resource Center/One Stop Staff
____ School Psychologist
____ Far Northern Regional Center
____ School District _____
____ Lassen Family Services
____ Lassen Aurora Network
____ 0-3 Infant/Toddler
____ School Behavioral Counselor

INFORMATION: Medical and Non-medical information may be exchanged, unless restricted to specific information listed below:

Client Name (print first name, middle initial and last name):	Date of Birth (month/day/year):

Important: Initial the appropriate box(s) and date as required.

☐ Records relating to_____

☐ Records from a specific visit – Date(s): From_____To_____
Location_____

☐ Attendance Only Records
☐ Billing or Payment info/records
☐ Consultation Reports
☐ Diagnosis
☐ Discharge Summary
☐ Medication(s)
☐ Medical, Neurological Assessment or Lab Tests (e.g., EEG, EKG)
☐ Progress Reports/Notes
☐ Psychiatric/ Psychological Assessment
☐ Treatment or Personal Service Plan
☐ X-Rays

Purpose: The information may be used only for the following reason(s):

☐ For continuity of care
☐ For treatment planning/ Case Management
☐ Allocation of resources
☐ Attorney name_____
☐ To provide medical services
☐ At the request of the client
☐ Other

IMPORTANT: Initial each box for acknowledgment

☐ **RE-USE OF INFORMATION:** I understand that in signing this authorization I am allowing release of the information identified above. In doing so, I am waiving provisions of both State and Federal laws that protect confidentiality of mental health, physical health, substance abuse and juvenile records. I also understand that any disclosure made regarding alcohol and/or drug abuse treatment is bound by Federal confidentiality rules, (Agencies are prohibited from making further disclosure of this information unless expressly permitted by your written consent. Agencies are also restricted from any use from this information to criminally investigate/prosecute any alcohol or drug abuse). Confidentiality is maintained in compliance with Education Code Section 49069 and California Welfare and Institutions Code, Section 4514, and 42 CFR Part 2.

☐ **CONDITIONS: I understand that I do not have to sign this Authorization form**
I understand that treatment, payments, enrollment and eligibility for benefits will not be based on my signing or refusing to sign this authorization, except if treatment is related to research, or if health care services are provided to me only for creating protected health information for release to a third party or otherwise required by law.

Client Name (print first name, middle initial and last name):	Date of Birth (month/day/year):

Important: Check the box and initial or sign and date as required.

☐ **RIGHT TO TAKE BACK AUTHORIZATION:** I understand that I have the right to take bake (revoke) my authorization. If I take back my authorization, I have to notify the County in writing; I have to sign the notice, and have to deliver the notice to the County at the following address:

Lassen County Health & Social Services HIPAA Privacy Officer
1445 Paul Bunyan Rd, Susanville, CA 96130

The notice will be in effect when received by the County. Any information already shared by this authorization ***cannot*** be taken back.

EXPIRATION: *This authorization will go into effect immediately and will remain in effect until_____ (write in date). If I do not write in a date, this authorization will remain in effect for one year from the date of my signature.*

Signature (Client of Representative, as appropriate)*:	Date (month/day/year):
* If form is signed by someone other than the client, state the relationship to client, and include required documentation of authority with the signed Authorization form. Name (print):_____ Relationship/ Authority: ☐ Parent ☐ Conservator ☐ Personal Representative ☐ Guardian ☐ Other _____	
Name of *County Representative who receives this form (print):*	Date (month/day/year):

☐ **DISTRIBUTION:** *Original copy of Authorization* form to client's records, copy of Authorization form provided to client or representative.

REVOCATION OF AUTHORIZATION:

Date Revoked	Received by	Agencies informed By/date	Remarks