Client Name: Expiration Date:

**PLUMAS COUNTY, CALIFORNIA**
**AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION**

Client (Patient) Information:
NAME:_____ Birthdate:_____

I, the undersigned, authorize Plumas County _____
Name of Department or Agency

to ☐ use ☐ disclosure ☐ exchange ☐ request the following Protected Health Information (PHI):

**PHI to be disclosed:** Check all that apply and identify clinic and time as needed.
☐ **Summary of PHI**
☐ **Psychiatric records** ☐**Psychotherapy notes** ☐ **Mental Health records**
Clinic where treated & when _____
_____
☐ **Alcohol / Substance Abuse Treatment records** ☐ **Urine tests**
☐ **Progress in Treatment** ☐ **Dates of Attendance**
Clinic where treated & when _____
☐ **Medical records relating to** _____
☐ **HIV test results / AIDS Treatment records**
☐ **All medical records**
Clinic where treated & when _____

**Purpose of the use or disclosure of PHI:**
_____

**Disclose PHI to:** _____
Name of person or agency
_____
Address telephone

**Unless otherwise revoked in writing, this authorization expires on:**
☐ Completion of this request (one time disclosure)
☐ One year from signature date below
☐ Expires as specified: _____

**Today's date:** _____ **Signature:** _____
**Printed name:** _____ **Relationship:** _____

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## WARNING

I understand that if the organization I have authorized to receive the information **is not** a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
Signature:_____
(patient/representative/spouse/financially responsible party)

## NOTICE OF RIGHTS

You may refuse to sign this Authorization.

You may revoke this authorization at any time. Your revocation must be in writing, signed by you or on your behalf and delivered to the Plumas County department where this Authorization form was signed.

Your revocation will be effective upon receipt except to the extent that it has already been acted upon or, if obtained for insurance purposes, another law permits the insurer the right to contest the policy or a claim under the policy.

You have a right to receive a copy of this Authorization.

Treatment, payment, enrollment and eligibility for benefits will not be conditioned on your providing or refusing to provide this Authorization except for research related treatment, pre-employment physicals or pre-enrollment risk determination.

You may inspect or obtain a copy of the health information that you are being asked to use or disclose.

## SIGNATURE

Date:_____ Time:_____

Signature:_____ Relationship: _____
patient/representative/spouse/financially responsible party

Employee witnessing signature:_____