DEPARTMENT OF HEALTH & SOCIAL SERVICES

SOLANO COUNTY

AUTHORIZATION TO RELEASE MEDICAL RECORDS & PROTECTED HEALTH INFORMATION

COMPLETE THIS FORM IF REQUESTING COPIES OF MEDICAL RECORDS, AUTHORIZING RECORDS TO BE SENT TO ANOTHER PERSON OR ENTITY, OR AUTHORIZING A VERBAL EXCHANGE OF INFORMATION. INCOMPLETE OR INVALID FORMS WILL NOT BE PROCESSED. IF YOU WISH TO VIEW OR INSPECT YOUR RECORDS, PLEASE USE "REQUEST FOR ACCESS" FORM.

1. AUTHORIZATION FOR USE, EXCHANGE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ALIAS(ES):		
ADDRESS:	CITY/STATE:	ZIP CODE:
DATE OF BIRTH:	TELEPHONE NUMBER:	SSN:

2. WHO HAS PERMISSION TO **RELEASE** YOUR INFORMATION? NAME OF INDIVIDUALS OR ORGANIZATIONS.	3. WHO HAS PERMISSION TO **RECEIVE** YOUR INFORMATION? NAME OF INDIVIDUALS OR ORGANIZATIONS.	4. Bi-Directional Exchange of Information?	
NAME(S) (& RELATIONSHIP IF APPLICABLE):	NAME(S) (& RELATIONSHIP IF APPLICABLE):	YES ☐ NO ☐	Initial Here
ADDRESS AND/OR PHONE NUMBER:	ADDRESS AND/OR PHONE NUMBER:		
FAX NUMBER:	FAX NUMBER:		

5. **PURPOSE OF DISCLOSURE:** PLEASE **INITIAL** THE REASON FOR YOUR REQUEST. THIS PORTION OF THE FORM MUST BE COMPLETE.			
Initial Here	Treatment or Consultation	Initial Here	Patient Request
Initial Here	Other:		

6. **DATE RANGE OF RECORDS TO BE RELEASED**

Please indicate the period that you are requesting records. The records covered by this release include **only** the records created during the period from (date)_____ to (date) _____. If dates are not specified, only one year of records will be provided.

7. **INITIAL** THE ITEMS YOU ARE REQUESTING TO BE RELEASED. ONLY THE ITEMS INITIALED WILL BE RELEASED.

	PRIMARY CARE RECORD TYPES		**MENTAL HEALTH RECORD TYPES**
Initial Here	History and Physical Exam	Initial Here	Diagnosis
Initial Here	Lab Test Results	Initial Here	Assessments
Initial Here	Progress Notes	Initial Here	Psychiatric Evaluations
Initial Here	X-Ray/Imaging Reports	Initial Here	Psychological Testing Results
Initial Here	Billing Records	Initial Here	Progress Notes
Initial Here	Dental Records	Initial Here	Consultations
Initial Here	Immunization Records ONLY	Initial Here	Lab Test Results
Initial Here	Behavioral Health Records/LCSW Records	Initial Here	Medications
			OTHER RECORD TYPES
Initial Here	HIV and HIV Antibody Test Results	Initial Here	OTHER:
Initial Here	Consult Notes	Initial Here	OTHER:

8. **MY RIGHTS**

I may refuse to sign this authorization. It will not affect my ability to get treatment.

- I have the right to revoke this authorization at any time in writing by submitting my revocation to the following address:

For Primary Care and Dental Records:
ATTN: Medical Records Unit
2101 Courage Drive, MS 10-150
Fairfield, CA 94533
Tel: (707) 784-2048
Fax: (707) 426-4813

For Mental Health Records:
ATTN: Central Medical Records
2101 Courage Drive, MS 10-300
Fairfield, CA 94533
Tel: (707) 784-2110
Fax: (707) 425-4072

- My revocation will take effect upon receipt, except for records that have already been released.
- I have a right to receive a copy of this authorization and will be offered a copy.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use and/or disclosure of.
- Information disclosed by this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases permitted and may no longer be protected by federal and state laws.

- In some cases, record requests may be denied. If you wish to appeal a record release denial, you may make a request in writing to the appropriate Medical Director in Primary Care or Behavioral Health with the Medical Records Unit that applies.

9. A general authorization for the release of medical records is NOT sufficient for releasing alcohol or drug related records. Such records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without specific written consent unless otherwise permitted by the law. 42 CFR Part 2 protected records are managed by the Behavioral Health Division.

I understand that fees may be charged for copies. Copies requested for or by a nonprofit attorney representing a Health and Social Services client will not be charged.

10. **This release expires on (date required)**:_____ (maximum 1 year from signature date).

11. **CLIENT SIGNATURE:** _____ Date:_____

12. **REPRESENTATIVE SIGNATURE:** _____ Date:_____

If signed by someone other than the patient, indicate the relationship by initialing the appropriate box and writing your name. Proof is required for legal guardianship or conservatorship. Please provide a copy of proof for the file.

Initial Here	Parent
Initial Here	Legal guardian of minor
Initial Here	Conservator or legal representative
Initial Here	Other:

13. For Medical Records Staff Use Only:

Approval to Disclose	☐ YES ☐ NO If no, state reason:
Medical Records staff name	
Approving clinician or provider signature and date, if applicable	
Medical Records staff sign and date	