



NAME OF INDIVIDUAL/PATIENT	
DATE OF BIRTH	
ADDRESS	CITY/STATE/ ZIP

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

- I hereby voluntarily authorize \_\_\_\_\_ to disclose the medical information indicated below to \_\_\_\_\_.
- The purpose for this disclosure is for \_\_\_\_\_.
- The information to be disclosed is:
  - \_\_\_ Entire Medical Record
  - \_\_\_ Only medical information from the period \_\_\_\_\_ to \_\_\_\_\_.
  - \_\_\_ Other (specify) \_\_\_\_\_

If you would like any of the following sensitive information disclosed, please indicate with a check mark below:

- \_\_\_ Alcohol/ Drug Abuse Treatment
- \_\_\_ HIV/ AIDS- related Treatment
- \_\_\_ Mental Health (other than psychotherapy notes\*)

Please check all approved methods of transmission for your medical information:

- \_\_\_ In-person pickup
- \_\_\_ Email\*    Email address \_\_\_\_\_
- \_\_\_ Fax        Fax number \_\_\_\_\_
- \_\_\_ Mail        Mailing address \_\_\_\_\_  
(please include city, state, & zip code)

\*The email transmission option does NOT apply to CARE Center clients. Protected Health Information will NOT be sent to CARE Center clients via email regardless of whether the Authorization for Release of PHI form has been signed.

- This authorization shall become effective immediately and shall remain in effect until \_\_\_\_\_ (date) or for one year from the date of signature if no date is entered.

I understand that I may revoke this authorization in writing at any time prior to the release of information from the Coastal Health District (CHD), and that revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

I understand that my eligibility for benefits, treatment or payment is not conditioned upon my provision of this authorization.

I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act.

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Print Authorized Representative's Name (if applicable)

\_\_\_\_\_  
Authorized Representative's Signature (if applicable)

Date \_\_\_\_\_

\**Psychotherapy notes* means notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. 45 C.F.R. 164.501.