Lake County Behavioral Health Services
BEHAVIORAL HEALTH RELEASE OF INFORMATION

Client Name:	Client Date of Birth:
Parent/Guardian/Conservator Name (if applicable):	

INFORMATION TO BE RELEASED

I hereby authorize Lake County Behavioral Health Services (LCBHS) to share (give and/or receive) the following protected health information, personal information, or other confidential information (called "PHI") about me:

INITIAL the types of PHI that you want to share

Pertaining to: ___Mental Health (MH) ___Substance Use Disorder (SUD)

_____Entire record (excluding psychotherapy notes)
_____Treatment verification and status as a client
_____Compliance in treatment, including attendance, progress, violations, or disciplinary actions and participation
_____Assessment information, including diagnosis and historical information
_____Psychiatric evaluation
_____Medications
_____Individual Treatment Plan
_____Immunization records
_____TB records
_____HIV/AIDS status
_____Medical/health information, including health diagnoses, treatment, prescriptions, etc.
_____Pregnancy test results
_____Legal information
_____Medical /lab test results
_____Discharge summary/information/support plan
_____Other *(describe in detail)*: _____

AUTHORIZED PROVIDERS/ORGANIZATIONS/AGENCIES

I authorize LCBHS to share (give and/or receive) information to/from the following parties:

INITIAL the providers, organizations, and/or agencies that can share your selected PHI

_____LCBHS Mental Health Program _____LCBHS Substance Use Disorder Program

Health Care Provider / Hospital / Dental Provider:
_____Adventist Health Clear Lake ___ Sutter Lakeside Hospital
_____Other: _____

Pharmacy:
_____CVS ___Rite Aid ___Walmart
_____Other: _____

Other Agencies/Organizations *(for SUD record releases, provide contact name, as noted)*:
_____Probation (*Contact name*: _____)
_____Superior Court of California, Lake County (*Contact name*: _____)

_____District Attorney (*Contact name*: _____)
_____Law enforcement (*Contact name*:_____)
_____Benefit program staff (Medi-Cal, WIC, CalWORKS, etc.)
(*Contact name*: _____)
_____Social Services/Adult Protective Services/Child Welfare Services
(*Contact name*: _____)
_____School(s) (specify): _____
(*Contact name*: _____)
_____Other Agency/Organization:_____
(*Contact name*: _____)
_____Other: _____
(*Contact name*: _____)

PURPOSE

I authorize sharing my PHI for the following purpose(s):

❒ Assessment ❒ Treatment planning ❒ Service coordination and/or referrals
❒ Verification of compliance with treatment plan or court order
❒ Other:_____

Limitations, if any: _____

ACKNOWLEDGEMENTS AND SIGNATURE

By signing this authorization:

- I authorize the use or disclosure of my protected health information and confidential information as described above for the purpose(s) listed. I understand that treatment, payment, enrollment, or eligibility for benefits will NOT be conditioned upon me signing this release of information.
- I understand that this release of information will disclose the fact that I am (or my child is) receiving behavioral health services from LCBHS.
- I understand that I have the right to revoke this authorization in writing to LCBHS at any time, except to the extent that action has already been taken. I understand that the recipient(s) may not redisclose Substance Use Treatment records unless they obtain another authorization directly from me, or unless the redisclosure is permitted by law. 42 CFR part 2 prohibits unauthorized disclosure of these records.
- I understand that I have a right to receive a copy of this authorization. I acknowledge that I have received a copy of this authorization; or by initialing, I decline to receive a copy:
Client initials to decline a copy_____
- Unless revoked sooner, I understand that this release will remain in effect for one (1) year from the date signed, or until (*specify date or condition*): _____

Client Signature:	Date:
Parent/Guardian/Conservator Signature (if applicable):	Date:
Name of Person obtaining Release:	
Signature of Person obtaining Release:	Date: