AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. PATIENT INFORMATION

Patient Name (Last, First)	Date of Birth	CDCR #

2. PARTIES TO RECEIVE INFORMATION (SELECT ONE)

☐ Patient ☐ Person or Organization Name_____
Address: _____ City/State/Zip: _____
Email Address/Fax: _____ Phone Number: _____

☐ Federal, state, county, and community-based organizations (including service providers, care coordinators, and case management staff) coordinating pre-release, transition, and post-release services of patient care.

3. PARTY TO RELEASE INFORMATION (SELECT ONE)

☐ CDCR

☐ Organization Name_____

4. PURPOSE

☐ Continuity of Care	☐ Personal Use	☐ Friends or Family	☐ Legal	☐ Other (specify)_____

5. INFORMATION TO BE RELEASED

A. Protected Health Information (select only 1, 2, or 3)

☐ 1. All information related to my care

☐ 2. The following information

- ☐ Mental health information
- ☐ Dental information
- ☐ Medical information
- ☐ Other information (specify) _____

☐ 3. Only HIV test results. I understand that HIV test results are released separate from other health care records. **I agree that by checking this HIV test results box, I authorize the release of specially protected health information. A new authorization will be required for subsequent disclosures.**

B. Specially Protected Health Information (select if applicable)

I understand the types of information below have extra confidentiality protections required by law. I would like the following specially protected health information released if it is in my record:

☐ Regional center developmental disability service records for care provided outside CDCR ("DDS Services")

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☐ Substance use treatment service records for care provided outside CDCR, including any services provided by a Narcotic Treatment Program ("Part 2 Program Services").

C. Dates of Service (select one)

☐ All dates of service

☐ Only dates of service from (insert dates) _____-_____

6. METHOD OF RELEASE OF INFORMATION (SELECT ALL THAT APPLY)

☐ Written or electronic records (e.g., facsimile, mail, CD)

☐ Verbal correspondence

7. EXPIRATION DATE

This authorization will remain in effect as follows (select one):

☐ This authorization shall remain in effect until revoked by the patient

☐ This authorization expires one year from the date signed below

☐ This authorization expires on the following date: _____.

8. RIGHTS

I understand:

- I may refuse to sign this authorization; refusal will not affect my ability to obtain treatment.
- I may revoke this authorization at any time by providing written notification to California Correctional Health Care Services, Health Information Management Services.
- If I revoke this authorization, my revocation will be effective upon receipt but will have no impact on uses or disclosures made while my authorization was valid.
- I may request a copy of this signed form.
- Information disclosed pursuant to this authorization may be subject to redisclosure by recipient and may no longer be subject to federal and state privacy law protection.
- Even if I do not authorize a release of health information, CDCR may share my confidential information for treatment, payment, and health care operations and other purposes required or permitted by law.

9. SIGNATURES

Signature of Patient/Agent	Date
Print Name of Patient/Agent	Relationship to Patient (if applicable)

If you are the Agent, you must attach documentation of your authority to act on behalf of the patient.