<b>.</b>			· · · · · · · · ·		
Consumer's Name (Print)	Date of E	Birth	Social Security	Number	
Give any other name under which consun	ner may have receiv	ed treatment:			
I AUTHORIZE TRI-CITY MENTAL HEALTH CENTER TO DISCLOSE TO:					
Agency Name		Pers	on to Receive (Required	0	
Street	Suite / Apt No.	City		Zip	
			IFIC TYPES OF INFORI	MATION that	
<ul> <li>Consultation Report</li> <li>Coordination Plan</li> <li>Diagnosis</li> </ul>	<ul> <li>Verbal Communic</li> <li>Progress Summa</li> <li>Progress Note</li> <li>Psychiatric Evalu</li> </ul>	ry Letter	Screening Evaluation     Other:     With approval from evaluate		
<b>REQUIRED</b> – The disclosure of records authori				ונ	
<ul> <li>IEP / Multi-Agency Case Planning (Chill</li> <li>Legal / Court Proceedings (provide apple</li> <li>Continued Care by the receiving facility</li> <li>Other</li> </ul>	<b>ildren)</b> olicable hearing date if / / doctor / therapist	known)	- 		
This authorization for release of the above infor	mation to the above na	amed persons or org	anizations will expire on:	(date).	
<ul> <li>I understand that:</li> <li>I authorize the use and/or disclosure of my understand that this Authorization is voluntated.</li> <li>I have the right to revoke this Authorization is at the address and location where I received received.</li> <li>The Notice of Privacy Practices provides into on my revocation.</li> <li>My treatment, payment, enrollment or eligibited.</li> <li>If the organization or person I have authorization may no longer be protected by fermination may no longer be protected by fermination to receive a copy of this Authoritation.</li> <li>THIS RELEASE/DISCLOSURE DOES NOT ALCOHOL/SUBSTANCE ABUSE INFORM.</li> </ul>	ry. by sending a signed not e services. The Auth structions for me shou lity for benefits will not ted to receive the infor ederal privacy regulation norization. AUTHORIZE THE DI	btice stopping this au orization will cease and I choose to revol- be affected if I do no mation is not a healt ons. SCLOSURE OF <i>PS</i>	thorization to Tri-City Mental on the date my valid revoca e my Authorization and inclu ot sign this Authorization. h plan or health care provide YCHOTHERAPY NOTES, HI	Health Center, ation request is udes limitations er; the released	
Date		Printed Name	of Person Witnessing Signatu	Iro	
Date		Finted Name	or reison withessing orginati	IIC	
Signature of:	Conservator	Signature of P	erson Witnessing Signature		
Relationship of requesting party:         □ Consumer         □ Parent of minor consumer         □ Guardian of minor consumer *         □ Under WIC 300, DCFS is minor's represented	tative*	Personal Representa Other:	r durable power of attorney* tive of deceased consumer*		
*Please furnish Tri-City MHC copies of <u>official</u> ap	pointment papers issu	ieu by the Court and/			
Printed Name of AMHD	AMHD Signa (Required to	i <b>ture</b> o process release/dis	Closure)		

**Confidential Consumer Information** California W&I Code Section 5328; CFR 42, Part 2, and HIPAA, 45 CFR Parts 160 and 164



**2008 N. Garey Ave., Pomona, CA 91767** 

Authorization for the Release/Disclosure of Information and/or Mental Health Records

□ 1900 Royalty Dr., Suite 180/280, Pomona 91767



## Authorization for the Release of Information and/or Mental Health Records

ТО

**Tri-City Mental Health Center** 

D 2008 N. Garey Avenue, Pomona, CA 91767

□ 1900 Royalty Dr., Suite 180/280, Pomona 91767

Consumer's Name (Print)	Date of Birth	S	ocial Security Number
Give any other name under which o	consumer may have receiv	ved treatment:	
The following agency is authorized treatment to Tri-City Mental Health	I to disclose information a		e course of my diagnosis and
Agency Name		Agency Telephone	
Street	Suite/Apt No.		
Zip		Name of AMHD at Tri-City (Required)	to receive information
This signed document authorizes to regarding treatment, payment and		to communicate with my	Care Coordination Team
Individual's Name	Relationship	Individua	l's Telephone
Individual's Name	Relationship	Individua	l's Telephone
Individual's Name	Relationship	Individua	l's Telephone
<ul> <li>only to the purpose of this authorization</li> <li>Assessments</li> <li>Closing Summary</li> <li>Coordination Plan</li> <li>Diagnosis</li> <li>An additional AUTHORIZATION m</li> <li>If not earlier revoked, this authoriz</li> <li>Expiration Date</li> <li>I understand that I have a right to a</li> <li>I understand a copy or facsimile of</li> </ul>	Discharge Summar Medication Report Progress Summary Lab Reports nust be obtained for any oth ation will terminate in one y	Letter     Ps     Control     Contro     Control     Control     Control     Control	ver comes first.
Date		Printed Name of Person W	litnessing Signature
	ardian 🗌 Conservator	Signature of Person Witne	essing Signature
Relationship of party requesting         Consumer       Conservation         Attorney-in-fact under durable power         Under WIC 300, DCFS is minor's	ator Parent of m ver of attorney	in <u>or</u> consumer	] Guardian of minor consumer e of deceased consumer
Printed Name of AMHD	AMHD's Signatur (Required to proce	<b>e</b> ss release/disclosure)	Date
		nsumer Information	Revised October 2014



## Authorization for the Release/Disclosure of Information and/or Mental Health Records <u>PHI Pertaining to HIV / AIDS</u>

2008 N. Garey Ave., Pomona, C.	A 91767	🛛 1900 Roya	Ity Dr., Suite 180/280, Pomona 91767	
Consumer's Name (Print)	Date of B	Birth	Social Security Number	
Give any other name under which co			,,,,,	
•				
INFORMATION MAY BE RELEA	ASED TO:			
Agency Name		Perso	n to Receive <i>(Required)</i>	
Street	Suite / Apt No.	City	Zip	
Assessments     Classing Summany	<ul> <li>IEP Case Planning</li> <li>Medication</li> </ul>	g (Children's) □	Psychological Testing* Service Plan	
<ul> <li>Closing Summary</li> <li>Consultation Report</li> </ul>	<ul> <li>Medication</li> <li>Verbal Communica</li> </ul>		Screening Evaluation	
	<ul> <li>Progress Summary</li> </ul>		Other:	
□ Diagnosis	Progress Note		omen	
<ul> <li>Discharge Summary</li> </ul>	Psychiatric Evaluat	tion *W	ith approval from evaluator	
I authorize Tri-City Mental health C			ning HIV/AIDS and/or PSYCHIATRIC	
			eased without my specific consent,	
except under a court order.				
Consumer Signature & Authorization	on:		Dated:	
<b>REQUIRED</b> – The disclosure of records a	uthorized as listed on this do	cument is required for t	the following <b>PURPOSE</b> :	
□ Legal / Court Proceedings (provid				
□ Other	ne application from high auto in h			
This authorization for release of the above	information to the above nar	med persons or organiz	ations will expire on:(date).	
I understand that:				
	of my individually identifiable	e health information as	described above for the purpose listed. I	
understand that this Authorization is vo				
			rization to Tri-City Mental Health Center, at	
			e my valid revocation request is received.	
<ul> <li>The Notice of Privacy Practices providing my revocation.</li> </ul>	les instructions for me should	1 I choose to revoke m	y Authorization and includes limitations on	
<ul> <li>My treatment, payment, enrollment or</li> </ul>	eligibility for benefits will not h	be affected if I do not si	on this Authorization	
			plan or health care provider; the released	
information may no longer be protected				
<ul> <li>I have the right to receive a copy of thi</li> </ul>				
• THIS RELEASE/DISCLOSURE DOES NOT AUTHORIZE THE DISCLOSURE OF <i>PSYCHOTHERAPY NOTES OR ALCOHOL/SUBSTANCE ABUSE</i> INFORMATION. ADDITIONAL AUTHORIZATIONS MUST BE OBTAINED.				
Date		Printed Name of I	Person Witnessing Signature	
Signature of:	dian   Conservator	Signature of Porc	on Witnessing Signature	
Relationship of requesting party:		Signature of Pers		
		onservator*		
Parent of minor consumer Attorney-in-fact under durable power of attorney*				
	□ Guardian of minor consumer * □ Personal Representative of deceased consumer*			
Under WIC 300, DCFS is minor's rep	resentative*		ower of Attorney	
*Please furnish Tri-City MHC copies of <u>official</u> appointment papers issued by the Court and/or Power of Attorney.				
Printed Name of AMHD	AMHD Signa		Date	
(Required to process release/disclosure)				
Confidential Consumer Information				



## Authorization for the Release/Disclosure of Information and/or Mental Health Records PHI Pertaining to ALCOHOL / SUBSTANCE ABUSE 100/200 0 01767 0000 N

LI 2008 N. Garey Ave., Pomo		900 Royalty Dr., Sulte 180/280, Pomona 91/6/		
Consumer's Name (Print)	Date of Birth	Social Security Number		
Give any other name under wh	ich consumer may have received treatment:			
INFORMATION MAY BE R	FL FASED TO:			
Agency Name		Person to Receive (Required)		
Agency Name		reison to Receive (Required)		
Street	Suite/Apt No. City	Zip		
Assessments	□ IEP Case Planning (Children's)			
Closing Summary	□ Medication	□ Service Plan		
Consultation Report	Verbal Communication	Screening Evaluation		
Coordination Plan	Progress Summary Letter	Other:		
Diagnosis	Progress Note			
Discharge Summary	Psychiatric Evaluation	*With approval from evaluator		
		ecords containing ALCOHOL/SUBSTANCE		
		that such information cannot be released		
without my specific consent, e Consumer Signature & Author		Dated:		
REQUIRED – The disclosure of rec	ords authorized as listed on this document is req	uired for the following PURPOSE:		
Legal / Court Proceedings	(provide applicable hearing date if known)			
Other				
This authorization for release of the	above information to the above named persons	or organizations will expire on: (date).		
I understand that:	LISUBSIA	NCE ABUSE		
	osure of my individually identifiable health inforr	mation as described above for the purpose listed. I		
understand that this Authorizatio				
		his authorization to Tri-City Mental Health Center, at		
		on the date my valid revocation request is received.		
<ul> <li>The Notice of Privacy Practices my revocation.</li> </ul>	provides instructions for me should I choose to	revoke my Authorization and includes limitations on		
5	ent or eligibility for benefits will not be affected if I	do not sign this Authorization		
		a health plan or health care provider; the released		
	otected by federal privacy regulations.			
• I have the right to receive a copy				
		E OF PSYCHOTHERAPY NOTES OR HIV/AIDS		
INFORMATION. ADDITIONAL	AUTHORIZATIONS MUST BE OBTAINED.			
		Name of Person Witnessing Signature		
Date	Finited	Name of Person Witnessing Signature		
Signature of:	Guardian  Conservator Signatu	ure of Person Witnessing Signature		
Relationship of requesting party:		~ ~		
	□ Conservator*			
Parent of minor consumer		t under durable power of attorney*		
<ul> <li>□ Guardian of minor consumer *</li> <li>□ Under WIC 300, DCFS is minor's representative*</li> <li>□ Other:</li> </ul>				
<ul> <li>Under WIC 300, DCFS is minor's representative*</li> <li>Other:</li></ul>				
Printed Name of AMHD	AMHD Signature	Date		
	(Required to process rele			
	Confidential Consumer Information			
	California W&I Code Section 5328;	Povised October 2014		

CFR 42, Part 2, and HIPAA, 45 CFR Parts 160 and 164