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

☐ **2008 N. Garey Ave., Pomona, CA 91767** ☐ **1900 Royalty Dr., Suite 180/280, Pomona 91767**

Consumer's Name (Print) | Date of Birth | Social Security Number

Give any other name under which consumer may have received treatment: _____

I AUTHORIZE TRI-CITY MENTAL HEALTH CENTER TO DISCLOSE TO:

Agency Name | **Person to Receive *(Required)***

Street | **Suite / Apt No.** | **City** | **Zip**

Information requested and to be released is limited to the **MINIMUM SPECIFIC TYPES OF INFORMATION** that pertains only to the purpose of this authorization:

- ☐ Assessments
- ☐ Closing Summary
- ☐ Consultation Report
- ☐ Coordination Plan
- ☐ Diagnosis
- ☐ Discharge Summary
- ☐ IEP Case Planning **(Children's)**
- ☐ Medication
- ☐ Verbal Communication
- ☐ Progress Summary Letter
- ☐ Progress Note
- ☐ Psychiatric Evaluation
- ☐ Psychological Testing*
- ☐ Service Plan
- ☐ Screening Evaluation
- ☐ Other:_____

**With approval from evaluator*

REQUIRED – The disclosure of records authorized as listed on this document is required for the following **PURPOSE**:

- ☐ IEP / Multi-Agency Case Planning ***(Children)***
- ☐ Legal / Court Proceedings *(provide applicable hearing date if known)* _____
- ☐ Continued Care by the receiving facility / doctor / therapist
- ☐ Other _____

This authorization for release of the above information to the above named persons or organizations will expire on:_____(date).

I understand that:

- I authorize the use and/or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this Authorization is voluntary.
- I have the right to revoke this Authorization by sending a signed notice stopping this authorization to Tri-City Mental Health Center, at the address and location where I receive services. The Authorization will cease on the date my valid revocation request is received.
- The Notice of Privacy Practices provides instructions for me should I choose to revoke my Authorization and includes limitations on my revocation.
- My treatment, payment, enrollment or eligibility for benefits will not be affected if I do not sign this Authorization.
- If the organization or person I have authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.
- I have the right to receive a copy of this Authorization.
- **THIS RELEASE/DISCLOSURE DOES NOT AUTHORIZE THE DISCLOSURE OF *PSYCHOTHERAPY NOTES, HIV/AIDS, OR ALCOHOL/SUBSTANCE ABUSE* INFORMATION. ADDITIONAL AUTHORIZATIONS MUST BE OBTAINED.**

Date | **Printed Name of Person Witnessing Signature**

Signature of: ☐ **Consumer** ☐ **Guardian** ☐ **Conservator** | **Signature of Person Witnessing Signature**

Relationship of requesting party:

- ☐ Consumer
- ☐ Parent of minor consumer
- ☐ Guardian of minor consumer *
- ☐ Under WIC 300, DCFS is minor's representative*
- ☐ Conservator*
- ☐ Attorney-in-fact under durable power of attorney*
- ☐ Personal Representative of deceased consumer*
- ☐ Other:_____

***Please furnish Tri-City MHC copies of official appointment papers issued by the Court and/or Power of Attorney.**

Printed Name of AMHD | **AMHD Signature** *(Required to process release/disclosure)* | **Date**

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

Revised October 2014

Authorization for the Release of Information and/or Mental Health Records
TO
Tri-City Mental Health Center

☐ 2008 N. Garey Avenue, Pomona, CA 91767 ☐ 1900 Royalty Dr., Suite 180/280, Pomona 91767

Consumer's Name (Print) ***Date of Birth*** ***Social Security Number***

Give any other name under which consumer may have received treatment: _____

The following agency is authorized to disclose information and records obtained in the course of my diagnosis and treatment to Tri-City Mental Health Center:

Agency Name ***Agency Telephone***

Street ***Suite/Apt No.***

Zip ***Name of AMHD at Tri-City to receive information (Required)***

This signed document authorizes the following individual(s) to communicate with my Care Coordination Team regarding treatment, payment and operational issues:

Individual's Name	***Relationship***	***Individual's Telephone***
Individual's Name	***Relationship***	***Individual's Telephone***
Individual's Name	***Relationship***	***Individual's Telephone***

Information requested and to be released is limited to the **MINIMUM SPECIFIC TYPES OF INFORMATION** that pertains only to the purpose of this authorization:

☐ *Assessments* ☐ *Discharge Summary* ☐ *Progress Notes*
☐ *Closing Summary* ☐ *Medication Report* ☐ *Psychiatric Evaluation*
☐ *Coordination Plan* ☐ *Progress Summary Letter* ☐ *Service Plan*
☐ *Diagnosis* ☐ *Lab Reports* ☐ *Other:* _____

- An additional AUTHORIZATION must be obtained for any other transfer or disclosure of information.
- If not earlier revoked, this authorization will terminate in one year, or at discharge, whichever comes first.
  Expiration Date_____
- I understand that I have a right to receive a copy of this authorization if I request.
- I understand a copy or facsimile of this authorization is of the same force and effect as the original.

Date ***Printed Name of Person Witnessing Signature***

Signature of ☐ ***Consumer*** ☐ ***Guardian*** ☐ ***Conservator*** ***Signature of Person Witnessing Signature***

Relationship of party requesting release of information to Tri-City:

☐ Consumer ☐ Conservator ☐ Parent of minor consumer ☐ Guardian of minor consumer
☐ Attorney-in-fact under durable power of attorney ☐ Personal Representative of deceased consumer
☐ Under WIC 300, DCFS is minor's representative ☐ Other:_____

Printed Name of AMHD ***AMHD's Signature*** ***Date***
(Required to process release/disclosure)

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

Revised October 2014

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

☐ **2008 N. Garey Ave., Pomona, CA 91767** ☐ **1900 Royalty Dr., Suite 180/280, Pomona 91767**

Consumer's Name (Print) _____ Date of Birth _____ Social Security Number _____

Give any other name under which consumer may have received treatment: _____

INFORMATION MAY BE RELEASED TO:

Agency Name _____ **Person to Receive *(Required)*** _____

Street _____ **Suite / Apt No.** _____ **City** _____ **Zip** _____

☐ Assessments	☐ IEP Case Planning **(Children's)**	☐ Psychological Testing*
☐ 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*

I authorize Tri-City Mental health Center to disclose any and all records containing HIV/AIDS and/or PSYCHIATRIC TREATMENT information. I understand that such information cannot be released without my specific consent, except under a court order.

Consumer Signature & Authorization: _____ **Dated:** _____

REQUIRED – The disclosure of records authorized as listed on this document is required 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:

- I authorize the use and/or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this Authorization is voluntary.
- I have the right to revoke this Authorization by sending a signed notice stopping this authorization to Tri-City Mental Health Center, at the address and location where I receive services. The Authorization will cease on the date my valid revocation request is received.
- The Notice of Privacy Practices provides instructions for me should I choose to revoke my Authorization and includes limitations on my revocation.
- My treatment, payment, enrollment or eligibility for benefits will not be affected if I do not sign this Authorization.
- If the organization or person I have authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.
- I have the right to receive a copy of this Authorization.
- **THIS RELEASE/DISCLOSURE DOES NOT AUTHORIZE THE DISCLOSURE OF *PSYCHOTHERAPY NOTES OR ALCOHOL/SUBSTANCE ABUSE* INFORMATION. ADDITIONAL AUTHORIZATIONS MUST BE OBTAINED.**

Date _____ **Printed Name of Person Witnessing Signature** _____

Signature of: ☐ **Consumer** ☐ **Guardian** ☐ **Conservator** _____ **Signature of Person Witnessing Signature** _____

Relationship of requesting party:

☐ Consumer	☐ Conservator*
☐ 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 representative*	☐ Other:_____

***Please furnish Tri-City MHC copies of official appointment papers issued by the Court and/or Power of Attorney.**

Printed Name of AMHD _____ **AMHD Signature** *(Required to process release/disclosure)* _____ **Date** _____

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

Revised October 2014

TRI·CITY Mental Health Services

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

PHI Pertaining to ALCOHOL / SUBSTANCE ABUSE

☐ **2008 N. Garey Ave., Pomona, CA 91767** ☐ **1900 Royalty Dr., Suite 180/280, Pomona 91767**

Consumer's Name (Print) _____ Date of Birth _____ Social Security Number _____

Give any other name under which consumer may have received treatment: _____

INFORMATION MAY BE RELEASED TO:

Agency Name _____ **Person to Receive *(Required)*** _____

Street _____ **Suite/Apt No.** _____ **City** _____ **Zip** _____

☐ Assessments	☐ IEP Case Planning **(Children's)**	☐ Psychological Testing*
☐ 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*

I authorize Tri-City Mental health Center to disclose any and all records containing ALCOHOL/SUBSTANCE ABUSE and/or PSYCHIATRIC TREATMENT information. I understand that such information cannot be released without my specific consent, except under a court order.

Consumer Signature & Authorization: _____ **Dated:** _____

REQUIRED – The disclosure of records authorized as listed on this document is required 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:

- I authorize the use and/or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this Authorization is voluntary.
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Date _____ **Printed Name of Person Witnessing Signature** _____

Signature of: ☐ **Consumer** ☐ **Guardian** ☐ **Conservator** _____ **Signature of Person Witnessing Signature** _____

Relationship of requesting party:

☐ Consumer	☐ Conservator*
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