925 Ygnacio Valley Road, Ste 205, Walnut Creek, CA 94596. Phone (925) 289-9022 Fax (888) 965-0556

www.CalCBH.com

Release of Information Form

Authorization for Use or Disclosure of Protected Health Information. (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164).

1. I (name of patient) _____ (DOB) _____authorize (**healthcare provider/Agency** releasing the information) _____ to use and disclose the protected health information below to (name of individual/agency to receive the information)_____ (Address/fax) _____

2. **Effective Period**: This authorization for release of information covers the period of healthcare from

A ( ) _____ to _____
B ( ) all past, present and future periods.

3. **Extent of authorization.**

a. ( ) I authorize the release of my complete health record (including records relating to mental health care, communicable disease, HIV/AIDS and treatment of alcohol and drug abuse. **OR**

b. ( ) I authorize the release of my **complete** health record with the exception of the follow information. ( ) mental health records. ( ) communicable diseases (including HIV and AIDS). ( ) Alcohol/drug abuse treatment. ( ) Other: Please Specify _____

4. This medical information may be used by the person/provider/agency I authorize to receive this information for medical treatment, consultation, billing, claims payment or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (**expiration date).** At this point the authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I can sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative _____

Printed Name of patient or representative _____ Date _____