Patient Information			
Last Name	First Name	Middle Name	Date of Birth
Address	City/State/Zip		Patient Case #

Person/Organization Providing Information	**Person/Organization Receiving Information**
Name Address City/State/Zip Phone/Fax Relation to Patient	Name Address City/State/Zip Phone/Fax Relation to Patient

☐ Information may be sent **and** received between the above two persons/organizations

Description of Information to be Released:

☐ Diagnosis ☐ Psychiatric Evaluation ☐ Discharge Summary ☐ Psychosocial Assessment ☐ Treatment Plan ☐ Seclusion/Restraint information ☐ Verbal notification: transfer to outside medical facility	☐ Results of psychological/ vocational testing ☐ Medical/neurological assessments, lab tests (EEG, EKG etc.) ☐ Verbal disclosure: treatment/hospital course ☐ Other	☐ Other evaluations/ assessments ☐ Legal ☐ HIV test results **Patient must initial** _____

☐ **Release information from the time period:** (date) **to** (date)

OR

☐ **Release any of the above information, regardless of date**

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Confidential Patient Information
See W & I Code, Section 5328
HIPAA Privacy Rule CFR Section 164.508
DSH-5671 (Rev 12/15)

ADDRESSOGRAPH/LABEL

Purpose for Release of Information		
☐ Evaluation	☐ Treatment Planning/Course	☐ Other

I understand:

I am authorizing the release of (agreeing to share) my personal health information. When information is sent to/from a state hospital, the other person/organization will know that I have received mental health services.

I am signing this Authorization voluntarily (by my own choice- without force), and my treatment will not be affected if I do not sign this authorization.

The information released may be re-shared with others if it is allowed or required by law.

Reasonable fees may be charged to the person requesting the information, in order to cover the cost of copying and postage.

I have the right to receive a copy of this Authorization.

Prior to any release of information, I have the right to revoke this Authorization (change my mind and not allow information to be released). To revoke, I will send a written request to the Health Information Management Department (HIMD) at my facility or to a member of my treatment team. When HIMD/treatment team receives the request, they will not release any additional information.

If not revoked, this Authorization will expire at the end of:

☐ 6 months ☐ One year ☐ Other date ☐ Event

Signature of Patient OR ☐ Parent/Guardian ☐ Conservator	Date
Printed Name	
Signature of Witness/Professional	Date
Printed Name	

ADDRESSOGRAPH/LABEL