Health and Human Services Agency
Mental Health and Public Health

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Form Instructions

PLEASE NOTE: For the purposes of this form and instruction memo, "Mental Health" does **NOT** include Shasta County Alcohol and Drug Programs.

The Health and Human Services Agency, Authorization to Use or Disclose Protected Health Information form allows clients to grant permission for Mental Health (MH) or Public Health (PH) to share information about the client with other individuals. This form replaces the standard Release of Information forms for both MH and PH. **NOTE: This form is NOT to be used for Alcohol and Drug Programs.**

The form contains drop-down menus to select from, as well as boxes that you can click on to check. Should your selection not be listed on the drop-down menu, you may click in the empty box and type in your selection. You will see that some boxes come pre-filled based on earlier boxes completed on the form, such as the chart number and client name. When completing this form, please make sure all information requested is provided. Failure to provide all information requested may invalidate the form.

To be more efficient, this form is intended to be completed electronically, printed, then appropriately initialed and signed by the client. However, the form can be printed and completed by hand.

CLIENT INFORMATION:
This section names the individual whose health information we are being authorized to release, as well as the information to be disclosed.

Each item being requested for disclosure needs to be hand-initialed by the client or their authorized representative once the form is printed. If the "entire record" is to be disclosed, it is not necessary to initial any other items. Be aware that information contained in the MH/PH chart that came from an outside agency can be re-disclosed **with the exception of any substance abuse treatment records received from a substance abuse treatment facility,** including Shasta County Alcohol and Drug Programs. (42 C.F.R. Part 2 strictly prohibits the re-release or

re-disclosure of substance abuse treatment records.) Substance abuse information disclosed by the client to MH/PH is part of the MH/PH chart and can be disclosed.

THE FOLLOWING IS AUTHORIZED TO MAKE THE DISCLOSURE:
This section names the agency that is releasing the information.

PURPOSE OF REQUESTED USE OR DISCLOSURE:
This section needs to be specific in its information. If the reason for the disclosure is not one of the four listed, check the "other" box and specify the reason by typing it in the space provided. Only one purpose may be selected.

THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING:
This section names the individual or entity authorized to receive the information to be released. Attachment A should be completed if the information is to be released to more the one individual or entity. When making a selection from the drop-down menu, read the selection carefully and make sure you are choosing the correct individual/agency with the correct address. Should the individual/entity you desire not be an available selection, you can type the correct information in the space provided.

RIGHTS, EXPIRATION AND NOTICE OF POTENTIAL RE-DISCLOSURE:
Right to Revoke: This information MUST be provided.
Expiration: If the date of expiration is not entered here, the form will expire 1 year from the date of signature.

SIGNATURE OF CLIENT OR LEGAL REPRESENTATIVE:
The date field is auto-populated with the current date; however, a different date can be typed in, or this field can be left blank if necessary. Once the date and legal representative information (if necessary) is entered, the form is ready to be printed and initialed and signed by the individual authorized to request the information.
Notice: The individual authorizing the release of information must initial this section as they are responsible for the costs associated with copying the requested documents.

THIS SPACE FOR USE BY SHASTA COUNTY STAFF ONLY"
Staff Member Initiating Request: The name of the Shasta County HHSA staff member assisting with the completion of this form.
Staff Member Completing Request: To be completed by Medical Records staff ONLY.

IMPORTANT: Do not alter this form in any way. To protect client confidentiality, do not electronically save this form.

ATTACHMENT A

If the information is to be released to more than one individual or entity, Attachment A should be completed. Up to 14 different individuals or entities may be entered per Attachment A. If more than 14 are needed, complete an additional Attachment A and change the page number in the lower right hand corner from “Page 3” to “Page 4”. If more than two Attachment A forms are needed, be sure and indicate the correct page number in the lower right hand corner.

The client information entered on Attachment A should match the client information entered on the authorization form.

Select the additional individual or entity authorized to receive the information to be released. When making a selection(s) from the drop-down menu, read the selection carefully and make sure you are choosing the correct individual/agency with the correct address. Should the individual/entity you desire not be an available selection, you can type the correct information in the space provided.

SIGNATURE OF CLIENT OR LEGAL REPRESENTATIVE:
The date field is auto-populated with the current date; however, a different date can be typed in, or this field can be left blank if necessary. Once Attachment A is completed it is ready to be printed and signed by the client or their legal representative. Attachment A should be attached to the initial authorization form.