CalMHSA
California Mental Health Services Authority

CalMHSA Custom Release of Information

CLIENT INFORMATION

Client Name:

Date of Birth: Age:

PROGRAM (INTERNAL AGENCY)

Is this Program the Discloser, Recipient, or both? *select one:*

○ Disclosing Entity ○ Receiving Entity

○ Both Disclosing and Receiving Entity (bidirectional disclosures)

Program Name:

Program Phone Number:

Program Address:

EXTERNAL AGENCY

Is this Program the Discloser, Recipient, or both? *select one:*

○ Disclosing Entity ○ Receiving Entity

○ Both Disclosing and Receiving Entity (bidirectional disclosures)

Name:

Relationship to Client:

Phone:

Address:

PURPOSE OF DISCLOSURE

Select the reason(s) for the disclosure

□ For treatment, payment, and/or health care operations

□ At the request of the client

□ Other:

INFORMATION TO BE DISCLOSED

□ Acknowledgement of Treatment

□ Summary of Treatment

□ Discharge Summary / Discharge Plan

□ Medication Information

□ Laboratory Information, including lab results

□ Assessment / Psychiatric Evaluation

□ Progress Notes

□ Billing and/or Insurance Information

□ Other:

DATE RANGE OF AUTHORIZED RECORDS

Is this authorization limited to records within a specific time frame? select one

○ No. All records, including historical and future records, are authorized for disclosure.

○ Yes. Only records that fall within the date range listed below are authorized for disclosure.

Start Date: End Date:

EXPIRATION

Authorization Expiration Type: select one

- ○ One year from the date the client/guardian signs.
- ○ When the client is discharged from the Program (Internal Entity) listed above. (Note: this requires manual entry upon end date upon that event. This is only allowed for TPO type releases.)
- ○ Other event (describe below). (Note: this requires manual entry upon end date upon that event. This is only allowed for TPO type releases.)

  Event:
- ○ A specific date: (*specify date*)

CLIENT RIGHTS

Authorization Expiration Type: select one

I understand and agree to the following:

Under state and federal confidentiality provisions, only the information specified in this authorization to disclose confidential information can be disclosed and can only be disclosed to the receiving entity listed in this authorization.

I may revoke this authorization at any time by contacting the Provider (Internal Entity) listed above. Information already disclosed under this authorization may not be retracted after revoking this authorization.

This authorization is voluntary, and that declining to sign this authorization will not impact my ability to get health care treatment, health insurance, or any governmental

benefits, except in limited circumstances allowed by law. If I refuse to sign, the program will still provide services except where disclosure is necessary for treatment, payment, or program operations permitted by law.

I have been given the chance to ask questions and receive answers pertaining to this document.

I have a right to a copy of this form. To receive a copy at any time, I should contact the Provider (Internal Entity) listed above.

If the information disclosed under this authorization is from a Substance Use Disorder (SUD) Treatment program that is regulated by 42 Code of Federal Regulations (CFR) Part 2, and I choose a HIPAA-covered provider or business associate to receive my information for treatment, payment, or health care operations, the recipient may redisclose my information as allowed by HIPAA. However, they cannot use or disclose my information in any civil, criminal, administrative, or legislative action against me, as prohibited by 42 CFR Part 2.

If I am signing as the guardian of the client, a new authorization may need to be signed if the privilege holder changes (e.g., if the client is removed from conservatorship, the client's guardian changes, or if the youth client comes to an age where they hold the privilege to their own records).

SIGNATURE

Guardian Name (if being signed by a Guardian):

Client/Guardian Signature:

Signature Date: