# County of Santa Cruz

Mental Health and Substance Abuse Services
1400 Emeline Avenue, Santa Cruz, CA 95060
Phone: (831) 454-4170 Fax: (831) 454-4663


## AUTHORIZATION TO RELEASE CONFIDENTIAL MENTAL HEALTH INFORMATION

**MY RIGHTS:** I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or eligibility for benefits.

I understand if I authorize disclosure of my protected health information to someone who is not covered by confidentiality laws, for example, a family member, it is possible that my information may be re-disclosed by that person to someone else.

I may revoke this authorization at any time. The revocation should be in writing and submitted to the following address: Quality Improvement Division, 1400 Emeline Avenue, 2nd floor, Santa Cruz, CA 95060. The revocation will take effect upon receipt of your request, except to the extent that others have acted in reliance upon this Authorization.

I have a right to receive a copy of this authorization.

**USE AND DISCLOSURE OF MENTAL HEALTH INFORMATION**

| **Client Name:** | **DOB:** | **SSN:** |
|---|---|---|

I, hereby authorize the _____ to release information

requested to _____

(Organization or Person authorized to **receive** the information)

Phone# Address City State Zip Code

**Please check appropriate boxes:**

☐ All information pertaining to my treatment FROM _____ TO _____

☐ Only the following records or types of health information (including any dates): _____

_____

**I specifically authorize release of the following confidential information: [please check appropriate boxes]:**

☐ Mental Health treatment information: FROM _____ TO_____

☐ Medication ☐ HIV Information ☐ AOD Information

☐ Other, specify: _____

**PURPOSE:** Purpose of requested use or disclosure: ☐ Client Request ☐ **Other**_____

**EXPIRATION: This authorization expires [insert date or event:]** _____

**Signature:** _____ **Date:** _____ **Time:** _____

**If signed by someone other than the client, state your legal relationship to the client:** _____

**Witness:** _____ **Date:** _____

**Legal Guardian or Conservator must provide a copy (within one year) of current appointment papers.**