



Behavioral Health and Recovery Services

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Providing Mental Health and Substance Use Disorders Treatment Services



Ukiah Offices: 1120 S. Dora St. • Ukiah • CA • 95482 • (707) 472-2300 • FAX (707) 472-2306
Fort Bragg Offices: Avila Center • 790-B S. Franklin St. • Fort Bragg • CA • 95437 • (707) 961-2665 • FAX (707) 961-2698
Willits Integrated Services Center: 474 E. Valley St. • Willits • CA • 95490 • (707) 456-3850 • FAX (707) 456-3808

AUTHORIZATION TO RELEASE OR RECEIVE CONFIDENTIAL INFORMATION

Client Name: _____ DOB: _____ Record # _____

AKA/Parent/Legal Guardian Name: _____

I am the ☐ Client ☐ Legal Guardian ☐ Conservator

I AUTHORIZE RECORDS/INFORMATION TO BE SENT TO:

Address: _____ City: _____ Zip: _____

I AUTHORIZE RECORDS/INFORMATION TO COME FROM:

Address: _____ City: _____ Zip: _____

I AUTHORIZE EXCHANGE OF INFORMATION between the above parties.

The above information is to include:

- ☐ Records subject to the Lanterman-Petris-Short Act (Psychiatric Information)
- ☐ HIV/AIDS Information
- ☐ Medical Information.

Please specify: _____

You have the right to exclude certain types of information. Please exclude:

Purpose of record request needed:

(If purpose is not specified, the release may not be honored)

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: Mendocino County Behavioral Health and Recovery Services, 1120 S. Dora Street, Ukiah, CA 95482, Attn: Medical Records. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

Information disclosure pursuant to this authorization could be re-disclosed by the recipient. Such disclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosures of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

☐ **RIGHT TO A COPY OF AUTHORIZATION:** I understand that I have a right to receive a copy of this authorization. ☐ **Yes**, I was offered a copy of this form.

Client Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Signature of Parent, Legal Guardian, Conservator: _____

Relationship: _____

If this consent is signed by the client and the release requires concurrence by the provider, the provider must sign below:

Mental Health Provider Signature: _____

Degree: _____ **Date:** _____

A photocopy or facsimile of this release is as valid as the original. Sender of records keeps the original copy.