



Alpine County Behavioral Health Services

75 C Diamond Valley Rd, Markleeville, CA 96120

Phone: (530) 694-1816

Fax: (530) 694-2387

AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Patient/Client Information:

Last Name	First Name	Birth Date	
		()	
Address	City, State	Zip Code	Phone

Person/Organization Authorized to EXCHANGE Information:

Alpine County Behavioral Health
75 C Diamond Valley Rd
Markleeville, CA 96120
Phone: 530-694-1816 Fax: 530-694-2387

Person/Organization Authorized to EXCHANGE Information:

Name/Organization	()		
	Phone		
Address	City, State	Zip Code	()
			Fax

Information to be Disclosed/Used: (INITIAL all that apply)

Mental Health Information Medical Information
 Alcohol/Drug Information Other _____

List information to be REQUESTED:

The purpose of this authorization is to use/disclose Protected Health Information: (Check all that apply)

To coordinate care Requested by client
 Other _____

This authorization is valid for one year, or until _____.

Date

I, the undersigned, understand:

- I sign this authorization voluntarily and Alpine County Behavioral Health may not condition treatment, payments, enrollment or eligibility for benefits or services based on this authorization.
- I may revoke this authorization in writing unless the disclosure has already been made or the disclosure is permitted or required by law.
- My revocation of this authorization must be in writing, signed by me or on my behalf and delivered to the following address:
75 C Diamond Valley Rd
Markleeville, CA 96120
- If my Protected Health Information includes alcohol and drug abuse information, I understand that the following statement applies: *Federal laws and regulations protect the confidentiality of alcohol and drug abuse records maintained by a program. Generally, disclosure of any information identifying a client as an alcohol or drug abuser is prohibited unless: 1) the client consents in writing, 2) the disclosure is allowed by a court order, 3) the disclosure is made to health care personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation, or 4) the client commits or threatens to commit a crime either at the program or against any person who works for the program. Violation of the federal laws and regulation by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. (42 USC section 290dd-22 and CFR 42 Part 2)*
- *Federal laws and regulation do not protect any information when child abuse or elder/dependent adult abuse is suspected by program staff. (CA Penal Code Sections 11164-11174.3 and § 368-368.5, CA Welfare & Institutions Code § 15630)*
- Re-disclosure of protected health information is prohibited without specific written consent from the person to whom the information pertains or as otherwise permitted by law.
- Information disclosed pursuant to this authorization may be disclosed by the recipient and no longer be protected by State and Federal Law.
- I have the right to receive a copy of this authorization.

Signature: _____

Date: _____

Print Name: _____

Your relationship to the client: Self

Parent/Legal Guardian