COUNTY OF SANTA CLARA
Behavioral Health Services

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1 Patient Name:_____
Date of Birth:_____
ID or Medical Record #_____
Address:_____
_____
Tel:_____

2 AUTHORIZATION: I give permission to Behavioral Health Services Department (BHSD) to use and release to
Recipient Name: Completed form can be emailed as secure email to: HHS-HIMAPI@hhs.sccgov.org
Address: Completed ROI form can be mailed to Medical Records ; 500 Tully Road; San Jose CA 95111
Phone:_____ Fax:_____

3 PURPOSE: The health information disclosed may only be used for the following purpose(s):_____
Requesting Records from BHSD to be released based on Application Program Interfaces (API)
_____

4 INFORMATION TO BE RELEASED _____
Date From: _____ To: _____

A. ☐ **Medical Record** ☐ All health information (e.g. diagnosis, test results, treatment); OR
☐ Images and/or Films ☐ Reports ☐ Billing ☐ Dental

B. ☐ HIV/AIDS Test Results (A separate authorization is required for each disclosure.) Initial: ___

C. ▣ Drug & Alcohol Treatment(e.g. diagnosis, test results, treatment, billing, attendance) Initial:___

D. ▣ Mental Health (e.g. diagnosis, test results, treatment, billing) Initial:___

E. ☐ Other_____ Initial:___

5 DELIVERY PREFERENCE:
☐ Mail ☐ Pick up ▣ Other_____

6 DELIVERY FORMAT:
☐ CD ☐ Film ☐ Paper ▣ Other_____

7 DURATION: This authorization is valid immediately and will be valid until_____(*give date*). If I do not write in a date, it will expire twelve months from the date it was signed.

8 CANCELLATION: I understand that I have a right to cancel this authorization any time. A cancellation (1) must be in writing, (2) sent or given to the Health Information Management Department and 3) is effective when it is received by the department. A cancellation will not apply to actions already taken by CSCHS under this authorization or if the authorization was required for getting insurance coverage and the insurer has a legal right to contest a claim. Verbal cancellation will be accepted for behavioral health medical record pursuant to WIC Section 5328. Call: 408-885-5770.

9 CONDITIONS: I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on my giving or refusing to give this authorization except if my treatment is related to research, or if health care services are given to me only for creating protected health information for release to a third party. I also understand that I may refuse to sign this authorization.
A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

10 REDISCLOSURE: Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA), although information protected by 42 CFR Part 2 continues to be subject to that protection. In addition, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

11 _____ _____ _____ _____
Patient/Patient's Representative Name Patient/Patient's Representative Signature Relationship Date