



**AUTHORIZATION FOR
CONTRA COSTA HEALTH SERVICES
TO USE OR DISCLOSE
HEALTH INFORMATION**

PATIENT NAME: FIRST / MIDDLE / LAST		DATE OF BIRTH	RECORD #
AKA (OTHER NAME)			
STREET ADDRESS	CITY	STATE	ZIP
		AREA CODE	PHONE#

I am the PATIENT GUARDIAN CONSERVATOR DESIGNEE and hereby authorize Contra Costa Health Services to use or disclose health information of the above named individual **TO:**

SEND TO (NAME OF PERSON, ORGANIZATION, AGENCY)			
STREET ADDRESS	CITY	STATE	ZIP
		AREA CODE	PHONE#
PURPOSE: THE DISCLOSURE OF THESE RECORDS IS FOR THE FOLLOWING PURPOSE(S) ONLY PHI DISCLOSURE: to obtain, transfer, inspect, inquire, and communicate verbally and in written form with any-all providers.			
DATES & TYPE OF INFORMATION TO BE DISCLOSED Any-all, first to last seen			

RE-DISCLOSURE: If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected. California law and federal law governing drug abuse patient records prohibit recipients of your health information from re-disclosing such information, except with your written authorization or as specifically required or permitted by law.

INFORMATION TO BE RELEASED: This is a full disclosure authorization of health care information which includes health care maintenance records, and medical, surgical, sexually-transmitted disease, mental health, alcohol or other drug abuse care and treatment records, if any. This consent also authorizes the disclosure of HIV test results, if any. These records will be disclosed unless you specify information you wish excluded. Please initial below information you do not want released:

 NO Exclusions
INITIAL

Exclude: Exclude HIV test results
INITIAL

 Exclude Substance Abuse treatment information
INITIAL

 Exclude Mental Health treatment information
INITIAL

 Exclude other: _____
INITIAL

This Authorization is effective immediately and will remain in effect until _____ or for three years from the date of signature, whichever comes first. I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the address where I received care. My revocation will be effective upon receipt, but will not be effective to the extent that Contra Costa Health Services has acted in reliance upon this Authorization.

I have a right to receive a copy of this Authorization. If I am being asked by Contra Costa Health Services to authorize this disclosure, I have a right to inspect or obtain a copy or such health information disclosed. I may refuse to sign this Authorization. Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this Authorization.

DATE	PATIENT SIGNATURE	SIGNATURE OF HOSPITAL STAFF WHEN REQUIRED (AB610, MH)	
SIGNATURE OF PARENT, GUARDIAN, CONSERVATOR, DESIGNEE		RELATIONSHIP	EMPLOYEE NAME
			DATE

