SAY San Diego Authorization for Release/Exchange Of Client Information

I, _____ hereby authorize the exchange/disclosure of information regarding myself and/or my child _____. I understand SAY is authorized by me to use or disclose my or my child's protected health information. I have read this authorization and understand what information will be used or disclosed, who may use or disclose the information and the recipient(s) of that information.

I specifically authorize any current employee of SAY, or any other individual listed below, to disclose my protected health information as described on this form to the recipients listed below.

I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information.

I further understand that I have the right to revoke this authorization, except to the extent that action has been taken in reliance on this authorization.

In order for the revocation to be effective, SAY must receive the revocation in writing. The revocation is to be given to your case manager/counselor and must contain the following:

- Client's name and address
- Effective date of this authorization and the recipient of the protected health information according to this authorization
- Client's desire to revoke this authorization
- The date of the revocation and the client's signature

I do hereby consent to the exchange and/or disclosure of protected health information contained in my record.

Between (name/function): SAY San Diego and _____

The disclosure or information and records authorized herein is required for the following purpose:

To provide group services

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I specifically request that the following information be released:

- ☐ Diagnosis
- ☐ Discharge Summary
- ☐ Mental Health Evaluation
- ☐ Consultation Reports
- ☐ Psychological Evaluation (Testing)
- ☐ Treatment Plan/Service Plan
- ☐ Legal Information
- ☐ Lab Results
- ☐ Psychiatric Records
- ☐ School Records
- ☐ Progress Notes
- ☒ Other attendance, level of participation, and regarding group services provided
- ☐ Drug and Alcohol records

I understand the information in my record may include information about behavioral or mental health services or treatment for alcohol and/or drug abuse.

I understand that I may revoke this authorization at any time before the information has been released; and that the authorization will automatically expire one year from today.

I have discussed the pros and cons of authorizing this release of information with my case manager. I am aware that this release may disclose the mental health, drug, alcohol, or juvenile justice/child welfare-related services that are being provided.

I may retain a copy of this authorization. Initial here if you desire a copy _____.

I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

Signing this authorization is not a condition of treatment.

_____ _____

(Signature of Client) (Date)

_____ _____

(Signature of Parent, Guardian, Conservator) (Date)

Please circle appropriate designation

Protected Health Information can be defined as: any information, including demographic information, that is created or received by a service provider that relates to the past, present, or future physical or mental health or condition of any individual, or payment for health services*.

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