AUTHORIZATION TO USE, RELEASE OR REQUEST FOR COPIES OF PROTECTED HEALTH INFORMATION
REGARDING MEDICAL, PSYCHIATRIC AND SUBSTANCE ABUSE RECORDS

FOR THE RECIPIENT OF THE INFORMATION:
If any of the requested records contain information regarding alcohol or drug abuse treatment, it is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I hereby authorize: AURORA BEHAVIORAL HEALTH CARE
11878 AVENUE OF INDUSTRY
SAN DIEGO, CA 92128 PHONE: (858) 675-4240 FAX: (858) 592-9395

To receive, use or release health information and records obtained during the course of treatment of:

Patient Name: _____ Date of Birth: _____

Address: _____ Patient/Requester's Phone: _____

_____ Social Security No.: _____

1. The information is to be used or disclosed To / From the following person or organization:

Person / Entity Name: _____

Relationship to Patient: Psychiatrist Primary Care Dr. Therapist Attorney Disability Family
Other: _____

Complete Address: _____

Phone Number: _____ Fax #: _____

2. Purpose: ☐ At the request of the patient ☐ Other: _____

Dates of Treatment (insert dates): _____. If this line is left blank, the treatment dates covered by this authorization are from the most recent pre-admission to discharge and claims resolution.

I understand this authorization extends to all or any part of the records/information designated below, which may include treatment for physical and mental illness, alcohol/drug abuse, HIV/AIDS test results or diagnoses.
The information to be used and /or released includes:

_____ Face Sheet
_____ Discharge Summary
_____ Discharge Instructions
_____ Psychiatric Evaluation
_____ History and Physical Exam
_____ Laboratory Data / X-Ray Reports
_____ Letter with dates of hospitalization
_____ Letter with date, physician name, diagnosis
_____ Verbal Communication
_____ Other _____
_____ Other _____

This authorization is limited to only information I have requested above to be used or disclosed to the persons/facilities named herein. I hereby release Aurora Behavioral Health Care, its employees and agents from all legal responsibilities or liability that may arise from the use or disclosure of medical records and other health information in reliance on this authorization.

Patient's Name _____

1. Expiration: I understand unless I revoke the authorization earlier, this authorization will automatically expire 180 days from the date this authorization is signed or on_____.
2. Re-disclosure: I understand information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be used or re-disclosed by the receiving party.
3. Refusal to sign: I understand I may refuse to sign this authorization and Aurora Behavioral Health Care will not condition treatment, payment, or eligibility for benefits on whether I sign this authorization.
4. Certification: I certify that I am (check whichever applies):
   - ☐ The patient, and the identification I have provided is true and correct.
   - ☐ The patient's authorized representative, and the identification and proof of authority I have provided are true and correct. Copies of legal documents supporting the assignment of this authority must be submitted. The signature of the authorized representative is required for patients who are conservatees under the Lanterman-Petris Act. This does not include conservatees under the Probate Code.
     * My relationship to the patient is that of: _____".
5. Revocation: I have the right to make a written request to stop the use or release of information at any time, although I understand I cannot do anything about information already used or disclosed under this authorization.
6. Minors: I understand minors over 12 years old must sign the authorization along with their parent / guardian.
7. Copy: I understand I will receive a copy of this completed form if I check yes: ☐ Yes ☐ No
8. I agree A copy or a fax of this form may be considered as effective as the original.
9. I understand I will be billed $15.00 and $.25/ page for copies of medical records for personal requests.

☐ **Mailed**	☐ **I will pick up**	☐ **Exchange Verbal Information**
☐ **Faxed:** _____		☐ **Secure Email**:_____

The confidentiality of medical, psychiatric and substance abuse information is protected by State and Federal Statutes, Rules and Regulations (including: California Confidentiality of Medical Information Act: California Administrative Code, Title 22; California Welfare and Institutions Code 5328; Title 42 of the Code of Federal Regulations; and HIPAA).

_____ _____
Patient Signature (Required if Adolescent) (Date)

_____ _____ _____
Parent or Legally Authorized Representative (Date) (Relationship to Patient)

_____ _____ _____
Staff Member/Witness Signature (Print Last Name) (Date)

OFFICE USE ONLY (To be completed by staff who releases information)

Information Released:_____

Date information was released:_____

Employee Signature: _____ Printed Name:_____

Please allow 5-7 business days for processing; extra time may be needed if retrieving from storage