# **HEALTH DISCLOSURE FORM**

# **AUTHORIZATION FOR USE, EXCHANGE, OR DISCLOSURE OF HEALTH INFORMATION**

Glenn County Health and Human Services Agency (HHSA) is an integrated agency that includes Public Health, Behavioral Health, and Social Services. In order to coordinate your care and better serve you, the HHSA seeks your authorization to share your health information. Completion of this document authorizes the disclosure, exchange, and use of your health information. Failure to provide all information requested will invalidate this authorization.

**Name of Client**: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address, City, State, Zip Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**USE AND DISCLOSURE OF HEALTH INFORMATION**

**I hereby authorize the individuals/agencies listed and initialed below to use, disclose, or exchange health information: *Please Initial next to each organization***

Glenn County Behavioral Health Glenn County Public Health Glenn County Social Services

|  |  |  |
| --- | --- | --- |
| **To release to Persons / Organizations authorized to receive the information:** | **Address** *(street, city, state, zip code)* | **Initial** |
| Butte College | 3536 Butte Campus Dr, Oroville CA  |  |
| California Department of Rehabilitation | 470 Rio Lindo #4, Chico CA 95926 |  |
| California Tribal TANF Partnership | 1250 East Ave Suite 10, Chico CA 95973 |  |
| Child and Family Services (GCOE) | 676 E Walker St, Orland CA 95963 |  |
| Dentist(s):       |       |  |
| Doctor(s):       |       |  |
| Far Northern Regional Center | 1377 E Lassen, Chico CA 95973 |  |
| First 5 Glenn County | 1035 W Wood, Willows CA 95988 |  |
| Glenn County Child Support Services  | 120 S Marshall Ave, Willows CA 95988 |  |
| Glenn County HHSA – Child Welfare Services | 420 E Laurel, Willows CA 95988 |  |
| Glenn County HHSA – Substance Use Programs  | 1187 E South St, Orland CA 95963 |  |
| Glenn County HHSA – Mental Health Programs | 242 N Villa Ave, Willows CA 95988 |  |
| Glenn County HHSA – Other:       |       |  |
| Glenn County HHSA –Public Assistance Programs | 420 E Laurel, Willows CA 95988 |  |
| Glenn County HHSA – Public Health Programs | 240 N Villa, Willows CA 95988 |  |
| Glenn County Office of Education (GCOE) | 311 S Villa, Willows CA 95988 |  |
| Glenn County Probation Department | 541 W Oak, Willows CA 95988 |  |
| Glenn County Superior Court/Treatment Court | 526 W Sycamore, Willows CA 95988 |  |
| Glenn Medical Center/Children’s Center  | 1133 W Sycamore, Willows CA 95988 |  |
| Hospital(s):       |       |  |

|  |  |  |
| --- | --- | --- |
| North Valley Indian Health  |       |  |
| Rape Crisis | 2889 Cohasset Rd # 2, Chico CA 95926 |  |
| School District(s):  |       |  |
| Other:       |       |  |
| Other:       |  |  |
| Other:       |       |  |
| Other:       |       |  |
| Other:       |       |  |
| Other:       |       |  |

**For substance use disorder information, include specific name(s) of the individual(s) in the “Other” fields for any Agency checked “Yes” or any Agency with initials next to it.**

**I specifically authorize release of the following information (check as appropriate):**

**Medical Health Information:** Information pertaining to my medical history, physical condition and treatment received:

All medical health information; **OR**

Only the following records or types of health information (including any dates): \_\_\_\_\_\_\_\_\_\_\_\_

**HIV Test Results**  (*initial*)

**Mental Health Information:** Information pertaining to my mental condition and treatment received:

All mental health information; **OR**

Only the following records or types of health information (including any dates):

 \_\_

**Substance Use Disorder Information:** Include an explicit description of any substance use disorder information to be disclosed:

 \_\_\_\_\_\_\_\_\_\_\_

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

**PURPOSE**

**Purpose of requested use or disclosure:**

Client request

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EXPIRATION**

**Unless revoked sooner, this authorization expires on (*date):*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MY RIGHTS**

* I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
* I may inspect or obtain a copy of the information to be used or disclosed. Fees may be charged for copy costs.
* I may revoke this authorization at any time, but I must do so in writing. My revocation will take effect upon receipt, except to the extent that action has already been taken in reliance upon it. If no date is provided, this authorization will expire one year from the date it is signed.
* I have a right to receive a copy of this information.
* 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). However, California law and federal drug and alcohol confidentiality laws prohibit 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.

**SIGNATURES**

Signature: Date: \_\_\_\_\_\_\_\_\_\_\_

 *(individual being served by HHSA/legal representative)*

If signed by a person other than the individual being served:

Name: Relationship: \_\_\_\_\_\_

 *(legal representative)*

**For Internal Use Only**

**Signature of staff obtaining information:**  \_\_\_\_**Date: Time:**

**Signature of staff entering information: \_\_\_\_\_\_\_\_Date: Time**:

*(if different from above)*