_____
_____
_____
_____
(Facility Name and Address)

AUTHORIZATION FOR RELEASE OF INFORMATION

A photostatic copy of my signature is as valid as the original

Consumer's Name: ____
Birth date: ____
Address: ____
Service Coordinator: ____

I authorize: _____to release to or receive from information and records.
(Person and/or Facility which has information/records)
(Street Address, City, State, Zip Code)

Please specify the information/ records you authorize to be released:

- ☐ **All information/records**
- ☐ **Educational**
- ☐ **Social**
- ☐ **Vocational**
- ☐ **Psychological (excluding psychotherapy)**
- ☐ **IFSP/IPP**
- ☐ **Other (specify):** _____.

Records from _____to _____. (enter dates)

The following information will not be released unless you specifically authorize it by initialing the relevant box (es) below:

☐ I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. Part 2).

☐ I specifically authorize the release of HIV/AIDS test results (Health and Safety Code Section 120980(g)).

☐ I specifically authorize the release of genetic testing information (Health and Safety Code Section 124980(j)).

NOTICE TO PROVIDERS OF INFORMATION

All information you supply to is subject to Section 4514, Welfare and Institutions Code, Confidentiality and Disclosure. Regulations allow for inspection and copying of all records by the client, his/her guardian or conservator or as otherwise permitted by the law.

NOTICE OF RECEIVERS OF INFORMATION

The information being released to you is confidential and subject to Section 4514, Welfare and Institutions Code. You are prohibited from making any further disclosure of this information without the informed, written consent of the person to whom this information pertains or his/her parent/guardian or conservator or as otherwise permitted by law.

The purpose of this release is for (check one or more):

☐ At the request of the consumer or consumer's legal representative

☐ Other (state reason): _____.

NOTICE

_____ and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS

This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your representative, and delivered to: Privacy Officer at Far Northern Regional Center, PO Box 492418 Redding, CA 96049

The revocation will take effect when FNRC receives it, except to the extent FNRC or others have already relied on it. You are entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires _____. If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

_____

Print Name

_____

Signature (Patient, Parent, Guardian)

_____ _____

Date Time

_____

Relationship to Patient
(Parent, Guardian, Conservator, Patient Representative)

_____

Witness (only if patient unable to sign) or Interpreter