Hosford Counseling and Psychological Services Clinic

AUTHORIZATION FOR RELEASE OF MEDICAL AND MENTAL HEALTH INFORMATION

Name___________________________________ Case #_______________ Date of Birth ___/___/_____ Phone ________________

Address_______________________________________ City_________________________ State_____________ Zip code_____________

I authorize:
(Person/facility that has mental health information)
Name Hosford Clinic

Address: UCSB, Education 1151, Santa Barbara, CA 93106-9490

Phone: (805) 893-8064

Fax: (805) 893-7762

To release medical and mental health information to:
(Person or facility to receive health information)
Name: ____

Address: ______________________________________

Phone: ____

Fax: ____

Type of disclosure: ☐ Verbal Information ☐ Copies of records

Please specify the information you authorize to be released:

☐ Mental health information (Subject to the Lanterman-Petris-Short Act , Welf & Inst. Code §5000 et seq.).
☐ Medical (This may include drug/alcohol and mental health information documented by a primary care practitioner)
☐ Drug and alcohol abuse, diagnosis or treatment information subject to federal law (42 C.F.R. §§2.34 and 2.35).
☐ HIV/AIDS test results (Health and Safety Code §120980(g)).

Type(s) of information, if not specified above (e.g. Summary Report)____

Specify date(s) of treatment, time period or condition:____

Limitations upon disclosure: ____

The purpose of this release is:

☐ At the request of the client/patient/patient representative

☐ Other (state reason) ___________________________________

EXPIRATION OF AUTHORIZATION: Unless otherwise revoked, this Authorization expires on ______________________.

If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

____
Client/Client Representative Signature

____
Relationship to Client

____
Date

NOTICE: UCSB 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) solely 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 client representative, and delivered to Hosford Clinic , UCSB, Santa Barbara, CA 93106-9490. The revocation will take effect when UCSB receives it, except to the extent UCSB or others have already relied on it. You are entitled to receive a copy of this Authorization.

**** PLEASE COMPLETE OTHER SIDE ****

Hosford Counseling and Psychological Services Clinic

AUTHORIZATION FOR RELEASE OF MEDICAL AND MENTAL HEALTH INFORMATION

Name___________________________________ Case #_______________ Date of Birth ___/___/_____ Phone ________________

Address_______________________________________ City ________________________ State __________ Zip code _______

I authorize: (Person/facility that has mental health information)	To release medical and mental health information to: (Person or facility to receive health information)
Name: ______________________________	Name: Hosford Clinic
Address: ______________________________	Address: UCSB, Education 1151, Santa Barbara, CA 93106
Phone: ______________________________	Phone: (805) 893-8064
Fax: ______________________________	Fax: (805) 893-7762

Type of disclosure: ☐ Verbal Information ☐ Copies of records

Please specify the information you authorize to be released:

- ☐ Mental health information (Subject to the Lanterman-Petris-Short Act , Welf & Inst. Code §5000 et seq.).
- ☐ Medical (This may include drug/alcohol and mental health information documented by a primary care practitioner)
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