COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

CLIENT'S INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
CASE NUMBER:	SSN:	DATE OF BIRTH:

HOW DO WE REACH YOU?

PHONE NUMBER:	ADDRESS:	CITY/STATE:	ZIP CODE:

IF YOU ARE NOT THE CLIENT:

PRINT YOUR NAME:	INDICATE YOUR RELATIONSHIP TO CLIENT:

WHO MAY SHARE THE INFORMATION:

NAME OF PERSON OR ENTITY: California Children's Services		PHONE NUMBER: (619) 528-4000
ADDRESS: 6160 Mission Gorge Rd, Suite 400	CITY/STATE: San Diego	ZIP CODE: 92120

PURPOSE OF REQUEST:
Transition Planning and Coordination of Services

WHO MAY RECEIVE THE INFORMATION

NAME OF PERSON OR ENTITY:		PHONE NUMBER:
ADDRESS	CITY/STATE:	ZIP CODE:

WHAT INFORMATION MAY BE SHARED

- ☐ Billing Records
- ☐ Complete Record
- ☐ Diagnosis Information
- ☐ Discharge Records
- ☐ Drug/Alcohol Treatment Information
- ☐ HIV/AIDS blood test results and any/all references to those
- ☐ Immunization Records
- ☐ Laboratory Results
- ☐ Medication Information
- ☐ Mental Health Records
- ☐ Photos/Videos
- ☐ Treatment/Service Information
- ☐ Other: _____

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WHAT YOUR AUTHORIZATION MEANS

Sensitive Information: Records may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or the Human Immunodeficiency Virus (HIV). They may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: You have the right to revoke this authorization at any time. If you revoke this authorization, you must do so in writing. Your revocation will not apply to information that has already been released.

Period of Disclosure: You can provide a start and/or end date (or event) for the authorization to be in effect. This means records will only be shared between the dates you specify.

This authorization will begin on the following Start Date: _____

- If no Start Date is specified, this authorization will be effective on the date signed.

This authorization will expire on the following End Date or Event: _____

- If no End Date or Event is specified, this authorization will expire one (1) calendar year from the date signed.

Redisclosure: If you have authorized protected health information to be disclosed to someone who is not legally required to keep it confidential, it may be redisclosed and will no longer be protected.

Other Rights:

1. Authorizing the disclosure of this information is voluntary. You can refuse to sign this authorization. You do not need to sign this form to receive treatment. However, if this authorization is needed for participation in a research study, enrollment in the research study may be denied.
2. You may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section 164.524.
3. You have right to receive a copy of this authorization. Would you like a copy of this authorization? ☐ Yes ☐ No
4. For more information about your privacy rights, see the Notice of Privacy Practices on our website: www.cosdcompliance.org or contact the Privacy Officer at 619-338-2808 or at PO Box 865524, San Diego, CA 92186-5524.

SIGNATURE

SIGNATURE:	DATE: