Shasta County Health and Human Services Agency (HHSA)
Authorization to Use or Disclose Protected Health Information

Failure to provide all information requested may invalidate this authorization. I hereby authorize use or disclosure of the named individual's health information as described below. I understand that this release may include the disclosure or exchange of information in written, verbal, electronic, and/or other forms.

Client Information:

Last Name: _____ First Name: _____ Middle Initial: ____

Address: _____

City: _____ State: ____ Zip: _____

Telephone Number: _____ Date of Birth: _____

Initial each item of information to be disclosed.

I specifically authorize the following release:

___ **Mental Health**	___ **Alcohol & Drug**	___ **Behavioral Health Team**
___ **Public Health**	___ **HIV**	___ **Perinatal**

Purpose/Limitation of requested use or disclosure (check one):

☐ Client Request ☐ Evaluation ☐ Continued Care Treatment ☐ Litigation

☑ Limitation/Other: Whole Person Care Pilot - include records from January 1, 2015

The following person or entity is authorized to make the disclosure:

Name: See Attachment A incorporated herein by reference

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

This information may be disclosed to:

Note: If Attachment A is included, **INITIAL** here _____, to authorize additional individuals or entities:

Name: See Attachment A incorporated herein by reference

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

Rights, Expiration and Notice of Potential Re-Disclosure:

I understand that I have the right to revoke this authorization. I understand if I revoke this authorization I must do so in writing and submit it to the following address:

_____

I understand that the revocation will not apply to information that has already been released based on this authorization. If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be re-disclosed and no longer protected, but any alcohol and/or drug treatment records cannot be re-disclosed without my written consent unless otherwise provided for by 42 CFR Part 2 and 45 CFR parts 160 and 164. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment or payment, enrollment, or eligibility for benefits. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I have the right to receive a copy of this authorization.

Expiration: Unless otherwise stated, this authorization expires one year from the date of signature.

Desired alternate/meaningful date of expiration: _____

Signature of Client or Legal Representative

I hereby authorize the use and disclosure of my information in accordance with the information entered above for the purposes described in this form. I understand this does not authorize the recipient of this disclosed information to further use or disclose this information, except as allowed or required by law. I further understand that information released then becomes the responsibility of the recipient and is no longer under the protection of the releasing entity.

Signature: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

If signed by legal representative, relationship to Client: _____

This space for use by Shasta County Staff only

Staff Member Initiating Request: _____ Date: _____

Staff Member Completing Request: _____ Date: _____

Chart #: _____

- ☐ Fax
- ☐ File
- ☐ Mail
- ☐ Transmit

Attachment A
Shasta County Health and Human Services Agency (HHSA)
Authorization to Use or Disclose Protected Health Information

This is an attachment to authorize additional persons and/or organizations to receive the health information described in the Authorization for Use or Disclosure of Information executed by (or on the behalf of): Last Name: _____ First Name: _____ Middle Initial: ___

Date of Authorization: _____ Date of Birth: _____ Chart #: _____

The following person(s) and/or entity(ies) are hereby incorporated into the above-described Authorization:

Name: HHSA - Adult Services - Mental Health Services, 2640 Breslauer Way, Redding, CA

Name: Partnership HealthPlan

Name: Hill Country Community Clinics, 29632 Highway 299 East, Round Mountain, CA 96084

Name: Shasta Community Health Centers, 1035 Placer St., Redding, CA 96001

Name: Shasta Regional Medical Center, 1100 Butte St., Redding, CA 96001

Name: Mercy Medical Center, 2715 Rosaline Ave., Redding, CA 96001

Name: Alyson Kohl - HHSA - Regional - Housing

Name: Katie Sears - HHSA - Regional - Housing

Name: Laura McDuffey - HHSA - Regional - Housing

Name: Natalie Shumaker - HHSA - Regional - Housing

Name: Robert Neil Young - HHSA - Regional - Housing

Name: Sarah Brown - HHSA - Regional - Housing

Name: Tamara Hurley-Marsala - HHSA - Regional - Housing

SIGNATURE OF CLIENT OR LEGAL REPRESENTATIVE

Signature: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

If signed by legal representative, relationship to Client: _____

Attachment A
Shasta County Health and Human Services Agency (HHSA)
Authorization to Use or Disclose Protected Health Information

This is an attachment to authorize additional persons and/or organizations to receive the health information described in the Authorization for Use or Disclosure of Information executed by (or on the behalf of): Last Name: _____ First Name: _____ Middle Initial: ___

Date of Authorization: _____ Date of Birth: _____ Chart #: _____

The following person(s) and/or entity(ies) are hereby incorporated into the above-described Authorization:

Name: Zach Kamla - HHSA - Regional - Housing

Name: Julissa Yanes - HHSA - Regional - Housing

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

SIGNATURE OF CLIENT OR LEGAL REPRESENTATIVE

Signature: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

If signed by legal representative, relationship to Client: _____