Buckelew Programs Client Authorization for Use or Disclosure of Protected Health Information (PHI)

AS OF JULY 1, 2023, BUCKELEW PROGRAMS WILL BE UTILIZING BOTH CREDIBLE AND SMARTCARE AS ITS ELECTRONIC HEALTH RECORD

Completion of this document authorizes Buckelew Programs, 201 Alameda Del Prado Suite 103 Novato, CA 94949 and **all its programs' sites** to disclose and/or use individually identifiable health information as set forth below, consistent with California and Federal law concerning the privacy of such information. **Failure to provide all information requested may invalidate this Authorization.**

Today's Date:

Client Legal First Name: Client Legal Last Name:

D.O.B: Client ID#:

This Authorization applies to the following information (please select all that apply):

Mental Health records, including those records protected by the Lanterman-Petris Short Act.

Sexually Transmitted Disease, acquired immunodeficiency syndrome (AIDS) records.

Human immunodeficiency virus (HIV) records.

Genetic Testing records.

Only the following health information (please specify)

For Marin County Only:

I authorize release of my PHI to the following Marin County agencies, entities/facilities and/or health care providers (Check all that apply)

Marin General Hospital

Public Guardian's Office

HHS Veteran's Services

Marin Community Clinics

HHS Mental Health Services

HHS Substance Use Services

HHS Medical Clinics

Homeward Bound

Community Action Marin

Other Marin Agency Specify

Other Marin Agency Specify

Date Range From To:

Please specify any instructions on the use or disclosure of your health information:

Date of expiration will be one year from this authorization unless an alternative date is provided.

For Sonoma County Only:

I authorize release of my PHI to the following Sonoma County agencies, entities/facilities and/or health care providers (Check all that apply)

Sonoma County Public Guardian's Office

Veteran's Services: (specify agency/health facility)

Sonoma County Community Clinics: (specify clinic)

Hospitals: (specify hospital)

Sonoma County Mental Health Services

Homelessness Services: (specify agency)

Substance Use Services: (specify service location)

Other Sonoma County Agency:

Other Sonoma County Agency:

Date Range From: To:

Please specify any instructions on the use or disclosure of your health information:

Date of expiration will be one year from this authorization unless an alternative date is provided.

RESTRICTIONS

California law prohibits the requestor from making further disclosure of my protected health information unless the Requestor obtains another authorization from me, or unless such disclosure is specifically required or permitted by law.

MY RIGHTS

I may refuse to sign this Authorization. I may inspect or obtain a copy of the protected health information that I am being asked to disclose. I have a right to receive a copy of this Authorization. I may revoke this Authorization at any time. My revocation must be in writing and sent to my primary clinic/clinical team.

My revocation will be effective upon receipt but will not be effective to the extent that the requestor or others have acted in reliance upon this Authorization.

Treatment, payment, enrollment and/or eligibility for benefits will not be based on my providing, or refusing to provide, this Authorization.

Please forward my health information to:

Name of person/organization:

Fax#: Phone#:

Address:

Email Address:

California law prohibits recipients of your health information from re-disclosing such information, except with your written authorization or as specifically required or permitted by law. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected.

Print Name Signature