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

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) Click or tap here to enter text.

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
- ☐ Other Marin Agency

Specific 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