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

BUCKELEW PROGRAMS USES CREDIBLE AND SMARTCARE AS ITS ELECTRONIC HEALTH RECORD

My completion of this document authorizes Buckelew Programs, 201 Alameda Del Prado Suite 103 Novato, CA 94949, and **all its programs' sites** to disclose, share, 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
- ☐ Only the following health information (please specify):
- ☐ Immunodeficiency syndrome (AIDS) records.
- ☐ Human immunodeficiency virus (HIV) records.
- ☐ Genetic Testing records.

☐ Reproductive Health Care (including gender affirming care, abortion and abortion related services, and contraception)

(1) A covered entity or business associate may not use or disclose protected health information potentially related to reproductive health care for purposes specified in § 164.512(d), (e), (f), or (g)(1), without obtaining an attestation that is valid under paragraph (b)(1) of this section from the person requesting the use or disclosure and complying with all applicable conditions of this part.

I authorize release of my PHI to the following agencies, entities/facilities, health care providers, and/or specific family members or authorized individuals (Check all that apply)

COUNTY ☐ **MARIN** ☐ **SONOMA** ☐ **NAPA** ☐ **OTHER**

- ☐ Hospital (Specify):
- ☐ Public Guardian's Office
- ☐ Veteran's Services
- ☐ Community Clinics
- ☐ Behavioral Health Services
- ☐ Substance Abuse Services
- ☐ Homeward Bound
- ☐ Community Action Marin
- ☐ Other Agency: _____
- ☐ Other Agency: _____
- ☐ Doctor (Specify): _____
- ☐ Dentist (Specify): _____
- ☐ Relative (Specify): _____
- ☐ Relative (Specify): _____
- ☐ Person (Specify): _____
- ☐ Person (Specify): _____
- ☐ Other (Specify): _____
- ☐ Other (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.

The information may be used and disclosed for the following purposes (check all that apply):

- ◯ Treatment including review and/or coordination of health care services with multiple providers.
- ◯ Referrals to other agencies for the purposes of providing public benefits and/or services
- ◯ At the request of the client or client's representative.
- ◯ Research and/or registries and databases.
- ◯ Development of training programs for clinical staff and independent practitioners.
- ◯ Other – Please Specify

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