CONTRA COSTA HEALTH SERVICES
- **CONTRA COSTA ALCOHOL & OTHER DRUG SERVICES**
- **CONTRA COSTA PUBLIC HEALTH**
- **CONTRA COSTA MENTAL HEALTH**
- **CONTRA COSTA REGIONAL MEDICAL CENTER**
- **CONTRA COSTA HEALTH CENTERS**

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

RELEASE OF CONFIDENTIALITY

PATIENT NAME	DATE OF BIRTH	RECORD #
AKA (OTHER NAME)		
STREET ADDRESS		PHONE #

I am the ☐ **PATIENT** ☐ **GUARDIAN** ☐ **CONSERVATOR** ☐ **DESIGNEE** and hereby authorize Contra Costa Health Services to use or disclose health information of the above named individual **TO**:

SEND TO (NAME OF PERSON, ORGANIZATION, AGENCY)	
STREET ADDRESS	PHONE #
PURPOSE FOR DISCLOSURE ☐ At the request of the individual.	
DATES & TYPE OF INFORMATION TO BE DISCLOSED	

RE-DISCLOSURE: 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. California law and a federal law governing drug abuse patient records prohibit recipients of your health information from re-disclosing such information, except with your written authorization or as specifically required or permitted by law.

INFORMATION TO BE RELEASED: This is a **full disclosure** authorization of health care information which includes health care maintenance records, and medical, surgical, sexually-transmitted disease, mental health, alcohol or other drug abuse care and treatment records, if any. This consent also authorizes the disclosure of HIV test results, if any. These records will be disclosed unless you specify information you wish excluded. Please initial below information you do not want released:

_____ INITIAL **NO** Exclusions

Exclude:
_____ INITIAL Exclude HIV test results
_____ INITIAL Exclude Substance Abuse treatment information
_____ INITIAL Exclude Mental Health treatment information
_____ INITIAL Exclude other information_____

This Authorization is effective immediately and will remain in effect for one year or until (date or event) _____, whichever comes first. I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the address where I received care. My revocation will be effective upon receipt, but will not be effective to the extent that Contra Costa Health Services has acted in reliance upon this Authorization.

I have a right to receive a copy of this Authorization. If I am being asked by Contra Costa Health Services to authorize this disclosure, I have a right to inspect or obtain a copy of such health information disclosed.

I may refuse to sign this Authorization. Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this Authorization.

Date	Patient Signature		SIGNATURE OF HOSPITAL STAFF WHEN REQUIRED	
Signature of Parent, Guardian, etc.		Relationship	EMPLOYEE NAME	DATE