

CONSENT FOR RELEASE OF DMH CLINICAL RECORD INFORMATION

I hereby authorize _____
FACILITY OR PROGRAM

to disclose records and/or information regarding _____
NAME OF PATIENT

date of birth ____ / ____ / _____, obtained in the course of his/her diagnosis and treatment to:

NAME OF REQUESTOR AGENCY/FACILITY/COMPANY/PHYSICIAN/ATTORNEY

STREET CITY STATE ZIP CODE

This disclosure of records is required for these purpose(s): _____

The information is subject to these limitations: _____

These records are protected by the California Welfare and Institutions Code Section 5328. Disclosure shall be limited to the information specified below (check appropriate items):

- ASSESSMENT/EVALUATION
- RESULTS OF PSYCHOLOGICAL TESTS
- DIAGNOSIS
- TREATMENT
- MEDICATION HISTORY/CURRENT MEDICATIONS
- LABORATORY RESULTS
- HIV TEST RESULTS
- OTHER: Specify

An additional consent must be obtained for any other record transfer or sensitive information disclosure. I also understand that the requestor may not further use or disclose the medical information unless he/she obtains another authorization from me or unless such use or disclosure is specifically required or permitted by law.

This authorization shall become effective ____ / ____ / _____ and is subject to revocation by the undersigned at any time except to the extent that the action has already been taken. If not earlier revoked, this consent shall terminate on ____ / ____ / _____. (Termination date should not be more than 90 days from effective date unless the treatment plan justifies ongoing communications with the above named agency. Under no circumstances should the termination date exceed one year.)

DATE SIGNATURE OF PATIENT

WITNESS SIGNATURE OF PARENT/GUARDIAN/CONSERVATOR/ATTORNEY FOR HEALTH CARE

I UNDERSTAND THAT I HAVE THE RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION IF I SO REQUEST.

CONSENT REVOKED ____ / ____ / _____
SIGNATURE OF PATIENT/PARENT/GUARDIAN/CONSERVATOR

The undersigned therapist, who is primarily responsible for the treatment of the patient, disapproves in part or whole of the requested release of information to the party specified above. If disclosure is disapproved, note below the reason for any partial or complete restriction.

SIGNATURE AND TITLE DATE

SUPERVISOR/PROGRAM DIRECTOR'S SIGNATURE AND TITLE DATE