|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CLIENT NAME:** | | | | **CLIENT NUMBER:** | |
| (Last, First, M.I.) | | | |  | |
| **CLIENT SSN:** | | | | **DATE OF BIRTH:** | |
| I request and authorize Santa Barbara County Department of Behavioral Wellness to release mental health client information (including electronic communications) of:  The type of information to be disclosed: **[Please initial type of information]**  **Mental Health Adult**     **Mental Health Minor\***     **Alcohol/Drug** | | | | | | |
| **Release Information To:**  Agency/Individual:   Address:  City:       State:    Zip: | | | | | | |
| Phone Number: | | | Fax Number: | | | |
| **Release Information From:**  Agency/Individual:  Address:  City:       State:    Zip: | | | | | | |
| Phone Number: | | | Fax Number: | | | |
| **Documents Requested:** **[Please initial requested information]** | | | | | | |
| Discharge Summary | Physician Progress Notes | | | | Clinical Staff Notes | |
| Physician Orders | Psychiatric Evaluation/Assessment | | | | Crisis Assessment | |
| Medications | Service Plan | | | | Aftercare Plan | |
| Psychological Testing Summary | | Dictated Summary of Service | | | | |
| Other: | | | | | | |
| Dates of service to be disclosed: From:         To:   This information will be used for the following purposes: | | | | | | |
|  | | | | | | |

|  |
| --- |
| This authorization will expire on:          **(No longer than 1 year from date of authorizing signature).** Date  This consent allows discussion and/or copies of ongoing treatment between the agencies noted above until termination of treatment or revocation or expiration of consent.  These records are protected under the federal regulations governing the privacy and confidentiality of alcohol, Drug and Mental Health Patient Records: 42 CFR, sec. 2.1; California Welfare & Institutions Code §5328 and 42 U.S.C., sections  290 ee-3; 45 C.F.R. Parts 160 and 164; Civil Code 56.10-56,38; Health and Safety Code(s) 123100-123149.5 California law prohibits the re-disclosure of private health information except by written request and authorization.    This release may be revoked by the client/guardian at any time by ***written*** request.  I would like a copy of this authorization  Yes  No  \*Client/Parent/Legal Guardian Signature:     Date:    Witness Signature:     Date:     Time:   * ***Please do not sign this form until the above information is completed.*** |

**MENTAL HEALTH THERAPIST SECTION**

|  |
| --- |
| The undersigned clinician/therapist who is in charge of the client, hereby  approves  disapproves the release of information and records to the party specified above. If disclosure is disapproved, please give reasons below. Also note below restrictions on the release of client records.    M.H. Professional Signature [LPHA] Date |