CONSENT TO RELEASE CONFIDENTIAL HEALTH INFORMATION

Client Name: _____DOB: _____ UID: _____

I, _____ and / or _____
(Client Name) (Parent/Legal Guardian/Conservator
authorize Momentum for Health (Momentum) to:

☐ **Release To:** ☐ **Obtain From:** ☐ **Exchange With:**

Agency / Person:	
Address:	
City, State, Zip:	
Phone:	
Fax:	
Relationship to Client:	

the following information pertaining to myself:

☐	Clinical Assessment
☐	Psychiatric Evaluation / Assessment
☐	Admission / Discharge Summary
☐	Treatment Plan
☐	Diagnosis
☐	Medication Orders / History
☐	Other:
☐	Emergency Contact Only

This disclosure of the above-mentioned specific mental health information is required to evaluation, treatment, or for the following purpose (Indicate, as specific as possible, the purpose and use of the disclosure): _____

☐ By checking this box, I give Momentum permission to communicate with the above named receiving agency / person via e-mail if necessary. I have read and understand the 4-1005B Texting and Email Risks / FAQ.

I understand that:

1. This information may be provided in person, by phone, fax, mail or by e-mail; (by e-mail if box above is checked)
2. I may revoke this consent by providing a written notice withdrawing my consent;
3. I understand if I refuse to sign this authorization, it will in no way impact my ability to access services with Momentum;

4. My mental health records are protected under the California Welfare and Institutions Code (WIC) and the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. The exceptions are set forth in the Notice of Privacy Practices;
5. The release discloses the fact that the named person has received mental health services;
6. If Momentum has already disclosed information in reliance on my consent, Momentum is not required to try to retrieve that information, should I later revoke this consent;
7. The information disclosed under this consent may be subject to re-disclosure by the recipient if allowed or required by law;
8. I have a right to receive a copy of this authorization, if I request it;
9. If not earlier revoked, this consent shall expire on the date, end of event or condition as described below: (Specify the date, event or condition, upon which this consent expires) If no date or event is noted here then this will automatically expire one year from date signed; _____ (expiration date)

_____ _____

(Client Signature) **(Date)**

Parent /Legal Guardian / Conservator: _____
(printed name)

Parent /Legal Guardian / Conservator: _____ _____
(signature) (date)

BELOW THIS LINE FOR OFFICE USE ONLY

I certify that I have reviewed with the client or with his/her representative this Consent to Release Confidential Health Information:

☐ I find that the client has the capacity to give informed consent or the client's representative has the legal authority to act for this client. I hereby authorize the release of the requested information.

☐ I find that the client does not have the capacity to give informed consent or the client's representative does not have or it is not clear if he/she has the legal authority to act for this client. I hereby do not authorize the release of the requested information.

Authorized Staff Printed Name: _____

Signature of Authorized Staff: _____ Date: _____