# RELEASE of CONFIDENTIAL HEALTH INFORMATION

**This Section must be completed for all Authorizations**

(Client Name) Please Print (Date of Birth) (Medical Record Number)

I, and / or

(Client Name) (Legal Guardian / Conservator)

Authorize Momentum for Health to release to and/or receive from the following information to the listed recipient.

*Note: If you're not the client, you may be asked to provide supporting documentation to verify that you are authorized to make this request on behalf of the patient.

## RECIPIENT INFORMATION:

Recipient Name:

Address: City, State, Zip Code:

Phone #: Fax #:

Relationship to Client:

**Request Delivery: Paper** ☐ **Encrypted Email** ☐ **Unencrypted Email** ☐ **Fax** ☐

There is some level of risk that a third party could see your information without your consent when receiving unencrypted electronic email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email. Note: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy).

Is this a request for psychotherapy notes?

☐ No, then you may check as many items below as you need.

☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.

Description of Information to be used or disclosed

☐ **All Pertinent Records** (Includes those listed below.)

- ☐ Consultation
- ☐ Problem List
- ☐ Discharge Instructions
- ☐ Admission Summary
- ☐ Emergency Contact Only
- ☐ Medication List
- ☐ Physician Orders
- ☐ Progress Notes
- ☐ Treatment Plan
- ☐ History and Physical
- ☐ Diagnosis
- ☐ Clinical/Laboratory Report
- ☐ Clinical Assessment
- ☐ Psychiatric Evaluation/Assessment

Other: _____

Information found in the records selected above may include alcohol use, drug use, psychiatric, HIV testing, HIV results or AIDS information. Treatment records from mental health, alcohol, drug, departments, and or HIV test results, will not be disclosed unless specifically requested. I specifically request disclosure of the following categories (check all that apply below.):

**HIV/AIDS Test Results** ☐ **Substance Abuse Records** ☐ **Alcohol Abuse Records** ☐

**The purpose of mental health information disclosure is required.** (Indicate, as specific as possible, the purpose and use of the disclosure):

**Your rights under the law**

I understand that:

1. I have the right to receive a copy of this authorization.
2. I may revoke this authorization at any time by providing written notice.
3. I may refuse to sign this authorization, and my refusal will not affect my ability to access services or payment.
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 Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for by regulations. The exceptions are set forth in the Notice of Privacy Practices.
5. This 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. If the recipient is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
9. Momentum is hereby released from any legal responsibility or liability for disclosure of information to the extent indicated and authorized.

## Expiration Date

I authorize the disclosure of the information specified below covering the following time-period. If no date is noted, this authorization will expire one (1) year from the date signed: Start Date: _____ End Date: _____

**Signature and Date (As required by law)**

Client Name: Date:

(PLEASE PRINT)

Client Signature:

*If signed by someone other than the client, print name and specify relationship to the client.

I understand that I have the right to revoke this Authorization at any time by sending a written notice of revocation to the Quality Improvement Department at 1922 The Alameda San Jose CA 95126. I understand that the revocation will become effective upon receipt. I understand that any information disclosed pursuant to this Authorization before the effective date of a revocation will not be subject to the revocation.

I revoke this Consent to Release Confidential Health Information as of:

Signature: Date