



**SACRAMENTO
CHILDREN'S HOME**

Giving children & families a better tomorrow since 1867

2750 Sutterville Road Sacramento, CA 95820

Phone: 916.452.3981 | Fax: 916.454.5031 | www.kidshome.org

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name:

Date of Birth:

By signing this form, I authorize the use and release of my own or my child's/client's protected health information by the Sacramento Children's Home and its business associates for purposes of treatment, payment and health care operations consistent with California and Federal law. This consent covers health and mental health providers employed by and under arrangement to the Sacramento Children's Home, including clinical staff.

I understand that this information may be needed to:

- Plan my and/or my child's/client's care and treatment
- Communicate among the various health professionals who are involved in my and/or my child's/client's care
- Assess the quality of my and/or my child's/client's care and review the care of direct care clinicians and their staff
- Provide information to a health insurance company or plan for the above named client
- Obtain payment from a health insurance company or plan for the above named client

Person/Agency RELEASING authorized Information:	Person/Agency RECEIVING authorized Information:
Reason for Disclosure:	

Dates and Types of Information I am authorizing to be released and/or received:

NOTE: Records relating to mental health, or alcohol/drug departments, or results of HIV antibody tests are specifically protected, and will not be disclosed unless you sign below:

Mental Health records	Signature: _____
Alcohol/Drug dependency treatment records	Signature: _____
HIV antibody test results	Signature: _____

PLEASE REVIEW YOUR HIPAA RIGHTS:

- I have the right to refuse to sign this authorization
- I may revoke this authorization at any time. If I choose to revoke this authorization, the Sacramento Children's Home must boldly mark this authorization form "revoked" and include the date of revocation.
- My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.
- I have a right to receive a copy of this authorization.
- I may inspect or obtain a copy of the health information that I am being asked to use or disclose, subject to certain limitations.
- Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.
- California law prohibits the person/agency receiving my and/or my child's/client's health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required as permitted by law.
- If I disclose protected health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected.

Signature (Client/Client's Authorized Representative)

Authorization Date

Print Name

Relationship to Client

THIS AUTHORIZATION EXPIRES ONE YEAR FROM DATE OF SIGNATURE OR AT CLOSURE OF SERVICES (IF PRIOR TO ONE YEAR)