ALISO RIDGE
BEHAVIORAL HEALTH

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information:

First Name: _____ **Last Name:**_____

Date of Birth: _____ **Phone Number:**_____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

I hereby authorize: Aliso Ridge Behavioral Health, 200 Freedom Lane, Aliso Viejo, CA 92656 to release protected health information to:

☐Self (same as above)	☐Provider	☐Other:_____
Name:		
Address:		
Phone:	Fax:	
☐Mail ☐Pick Up (photo ID REQUIRED)	☐Fax	☐E-mail:_____

Record(s) to be Released (required):

☐ Free Copy (Discharge summary, History & Physical, Psychiatric Evaluation, Labs)
☐ Discharge Summary ☐Lab Report ☐History & Physical ☐Psychiatric Evaluation
☐ Other: _____
☐ Entire record. I understand I will be subjected to a 10¢ per page fee plus clerical fees of $15.00 per hour.

Date(s) of Service Requested (required): _____

By initialing below, I expressly consent the following type(s) of information to be released (optional):
_____ Substance Abuse _____ Psychotherapy Notes
_____ HIV test results (separate consent required for each release of HIV test results)
_____ Genetic test results

Purpose of Request:
☐Continuity of Care ☐Legal
☐Insurance ☐Personal Use
☐Other:_____

This form may be submitted by mail/email/fax:
Aliso Ridge Behavioral Health, 200 Freedom Lane
Aliso Viejo, CA 92656 | roi@alisoridgebh.com
fax: 949-221-3603

ALISO RIDGE
BEHAVIORAL HEALTH

Patient's Rights:

I understand that I have the following rights with respect to this authorization:

1. I understand that information to be released may include information regarding drug or alcohol abuse, psychological or psychiatric impairments, confidential communications, HIV and/or AIDS, physical conditions or other information which may be privileged or confidential under State and/or Federal law.
2. The recipient of protected health information is prohibited from redisclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law in which case the recipient may not be required to keep the information confidential, may be subject to redisclosure, and no longer protected by federal law.
3. I understand this authorization is voluntary. I may not be required to sign this authorization as a condition to obtaining treatment or payment or my enrollment/eligibility for benefits.
4. I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to **Aliso Ridge Behavioral Health, 200 Freedom Lane, Aliso Viejo, CA 92656**. Such revocation will be effective upon receipt, does not apply to action taken in reliance of this authorization, and will expire on _____ or (12) months after the date of signature below.
5. I have the right to receive a copy of this authorization.

Under California law, a health care provider may decline to permit inspection or provide copies of mental health records only if the provider determines there is a substantial risk of significant adverse or detrimental consequences to a patient in seeing or receiving a copy of her/his mental health records. If determined, the health care provider shall make a written record, to be included with the mental health records requested, noting the date of the request and explaining the health care provider's reason for refusing to permit inspection or provide copies of the records, including a description of the specific adverse or detrimental consequences to the patient that the provider anticipates would occur if inspection or copying were permitted. The health care provider shall permit inspection by, or provide copies of the mental health records to, a licensed physician and surgeon, licensed psychologist, licensed marriage and family therapist, licensed clinical social worker, or licensed professional clinical counselor, designated by request of the patient.

The confidentiality of medical, psychiatric and substance abuse information is protected by state and federal statutes, rules and regulations (including California Confidentiality of Medical Information Act; California Administrative Code, Title 22, California Welfare and Institutions Code, Section 5328; and Title 42 of the Code of Federal Regulations). These statutes and rules and regulations require that the patient give informed consent prior to the release of any health/hospital records or information, except as specifically provided for within the statutes, rules and regulations.

Signature of Patient or Authorized Representative:	**Date:**
Print Name:	
Relationship (if other than Patient):	
Witnessed by:	**Date:**