AltaMed
QUALITY CARE WITHOUT EXCEPTION™

Behavioral Health Services

AUTHORIZATION For Use and Disclosure Behavioral Health Services

I hereby authorize AltaMed Health Services Corporation to release/request behavioral health records to the person/organization named below. **Failure to complete all sections of this form may invalidate this request.**

RELEASE INFORMATION FROM:

Patient Name: _____
Date of Birth: _____
Patient Chart #: _____
Phone #: _____
Email: _____

RELEASE INFORMATION TO:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone#: _____
Fax#: _____

The disclosure of behavioral health records requested herein is meant for the following purpose (Choose only one):

PURPOSE OF INFORMATION TO BE RELEASED:

- ☐ Personal Use
- ☐ Second Medical Opinion
- ☐ Legal Purpose
- ☐ Further Medical Care
- ☐ Changing Providers
- ☐ Social Security Disability
- ☐ Other (Please Specify): _____

Dates of Service: From: ___/___/___ **To**: ___/___/___ **Or** ☐ All Dates of Service

When multiple copies of behavioral health records are requested for multiple purposes, the patient/legal representative must complete one release/request form for each different purpose.

TYPE OF INFORMATION TO BE RELEASED:

- ☐ Clinical Therapy Notes
- ☐ Behavioral Health Notes
- ☐ Substance Abuse
- ☐ My Entire Behavioral Health Record to another Licensed Behavioral Health Provider for Further Medical Care Only.
- ☐ My Entire Behavioral Health Record to a Non-Licensed Behavioral Health Provider; Not for Further Medical Care.
- ☐ Other (Please Specify): _____

METHOD FOR PROCESSING RELEASE:

- ☐ Mail to Address Listed Above
- ☐ Patient/Designee/Legal Representative to Pick Up
- ☐ Fax to Provider Number Above
- ☐ Other (Please Specify):

If signed by someone other than patient, indicate relationship

- ☐ Parent/Legal Guardian
- ☐ Durable Power of Attorney
- ☐ Caregiver
- ☐ Personal/Legal Representative
- ☐ Other (Please Specify): _____

Patient's Signature	Date
Witness' Full Name	Title
Witness' Signature	Date

The witness must be an Altamed Health Services Corporation employee who has verified the patient's identity. If a patient's legal representative is placing this request, then the witness will verify credentials (i.e, power of attorney, etc) and file copies of proof in the patient's record.

NO RELEASE/REQUEST OF BEHAVIORAL HEALTH RECORDS CAN BE PROCESSED WITHOUT THE SIGNATURE OF THE PATIENT AND WITNESS.

FOR OFFICE USE ONLY

I, a **California licensed** physician/clinical psychologist/psychiatrist/clinical social worker, am in charge of and/or supervise this patient's behavioral health treatment.
As such, I hereby ❑ approve ❑ disapprove the disclosure of the records requested herein.

Disclosure disapproval reasons:

- ❑ The patient previously agreed to a temporary denial of access to his/her mental health records only while he/she (the patient) is part of a research project that includes treatment. Thus, the release of the records requested herein is prohibited by a patient's signed consent form. (Provide a copy of the signed consent form).
- ❑ The patient's access to his/her behavioral health records are subject to and may be denied under Privacy Act 5 USC 522a.
- ❑ The behavioral health record(s) were obtained from someone other that a healthcare provider under a promise of confidentiality and access to the requested information would reveal the source of information.
- ❑ An Altamed licensed mental health provider has determined that the access to the requested record is likely to endanger the life and/or physical safety of the patient and/or another person.
- ❑ The behavioral health record(s) make reference to another person (unless the person is a healthcare provider) and a licensed mental health provider has determined that disclosure of the requested records is likely to cause harm to the patient and/or another person.
- ❑ The request for access is made by patient's personal representative (excludes patient's attorney) and an Altamed licensed healthcare professional has determined the provision of access to such representative is likely to cause substantial harm to the individual or another person.
- ❑ The level of detail requested to be released for the person/entity listed above is considered inappropriate because he/she is not a licensed mental health provider. In lieu of the record(s) requested, the behavioral health provider will prepare a summary report that he/she considers is appropriate to release.
  See the **Approval Guidelines** section for detail on the disclosure of records for this request.

Disclosure restrictions:
Indicate which entries you disapprove for disclosure:

Date of entry: _____ Entry type: _____

Indicate the entity / individual or any legal representative to whom disclosure should be denied:

Entity and/or individual's name: _____

Relationship to the patient: _____

Approval Guidelines:
The following release/request has been granted:
❑ Release as requested ❑ Full disclosure ❑ Partial disclosure ❑ Limited disclosure

Provider's Signature:	Degree/s:	Date: