Authorization for Use and Disclosure
Confidential Sensitive Information

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

Failure to complete all sections of this form may invalidate this request.

Patient/Participant/Client Information			
Patient's Last Name: DOB:		Phone Number:	
Patient's First Name:		E-Mail Address:	
Entity/Person To Disclose PHI		**Entity/Person To Receive PHI**	
Name:		Name:	
Address:		Address:	
City:	Zip:	City:	Zip:
Phone:	Fax:	Phone:	Fax:

I hereby authorize AltaMed Health Services Corporation to disclose confidential sensitive health information to the person/organization named above:

PURPOSE OF INFORMATION TO BE RELEASED:

☐ Personal Use ☐ Changing Physicians ☐ Legal Investigation
☐ Second Medical Opinion ☐ Social Security Disability ☐ Other: _____

DATES OF SERVICE:

From: ____/_____/_____ To: ____/_____/_____ OR ☐ All Dates of Service

TYPE OF INFORMATION TO BE RELEASED:

☐ Behavioral Health Notes ☐ Substance Abuse Records
☐ Clinical Therapy Notes ☐ Other (Please Specify): _____
☐ Entire Behavioral Health Record to Licensed Behavioral Health Provider
☐ Entire Behavioral Health Record to Non-Licensed Behavioral Health Provider

METHOD FOR PROCESSING RELEASE:

☐ Mail to Address Listed Above ☐ Fax to Provider Number Above
☐ MyAltaMed Patient Portal ☐ Other (Please Specify):_____
☐ Patient/Designee/Legal Representative to pick up at clinic

If picked up by someone other than patient write individual name: _____

EXPIRATION: I understand that this authorization will be in effect until:

Expiration Date: _____/_____/_____ or Event: _____.
If there is no expiration date this authorization will expire 6 months after the date of signature.

Authorization for Use and Disclosure
Confidential Sensitive Information

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

If signed by someone other than patient, indicate relationship:

☐ Parent/Legal Guardian ☐ Personal/Legal Representative

☐ Caregiver ☐ Durable Power of Attorney

☐ Other (Please Specify):_____

_____ ____/_____/____
Patient/Legal Representative Signature Date

_____ _____
Witness' Printed 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.

FOR OFFICE USE ONLY

I, a California Licensed physician/clinical psychologist/psychiatrist/clinical social worker, am in charge of and/or supervise the 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.

Authorization for Use and Disclosure
Confidential Sensitive Information

AltaMed
QUALITY CARE WITHOUT EXCEPTION™

☐ 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.

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

_____ ____/_____/____

Providers' Signature Date