AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION AND CONFIDENTIAL INFORMATION

Ombudsman Services Unit
HIPAA Privacy Rule 45 C.F.R., Section 164.508

Welfare and Institutions Code, Section 5328 (c)

INSTRUCTIONS: Use this form to obtain authorization to disclose protected health information or other confidential information to third parties when a client is requesting Ombudsman Services to obtain aid, insurance or medical assistance.

Client's Name _____ Birth Date ____|____|____
Month Day Year

I, _____ and/or _____
Name of Client Name of Parent/Guardian/Conservator

hereby authorize the Department of Mental Health to disclose the following protected health information or other confidential information:

- ☐ Diagnosis
- ☐ Psychiatric Evaluation Information
- ☐ Social Security Number
- ☐ Address and Telephone Number
- ☐ Date of Birth
- ☐ Other (specify)
  _____
  _____
  _____
  _____
  _____

to _____
Name of Agency/Person/Organization

_____
Address (Street, City, State and Zip Code)

For the purpose of: _____
_____.

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By signing this authorization:

- I authorize the use or disclosure of my protected health information and confidential information as described above for the purpose listed. I understand that this authorization is voluntary.
- I understand that I have a right to receive a copy of this authorization.
- I understand that I may revoke this authorization at anytime by submitting a signed letter addressed to the Ombudsman Services Unit, located at 1500 Capitol, Suite 72.220, Sacramento, CA 95814 stating that I wish to revoke this authorization to release my protected health information and confidential information. I understand I may email my signed revocation letter to the Ombudsman Services Unit's email address at MHOmbudsman@dhcs.ca.gov.If revoked, the authorization will stop on the date the request is received or specified in the revocation letter. [45 C.F.R. § 164.508(c)(2)(ii)& Civil Code § 56.11(h)] If not revoked, it shall terminate at the end of (check one):
  ☐ 6 months ☐ One year or ☐ Specify Date _____

_____ Date: ____|____|____
Signature of Client Month Day Year

_____ Date: ____|____|____
Signature of Parent/Guardian/Conservator, if Applicable Month Day Year

_____ Date: ____|____|____

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Identifying Information
☐ Copy of Identification Attached Type _____(CA Driver's License, CA DMV Identification Card, State or Federal Employee ID Card) Number _____
If No Identification Is Attached, Your Signature Must Be Notarized. Notarized By _____ On_____(Date) Notary Public Number _____ Unofficial Unless Stamped by Notary Public