Patient Information

Last Name	First Name	Middle Name	Date of Birth

Address	City/State/Zip			Patient Case #

Person/Organization Providing Information		Person/Organization Receiving Information	
Name		Name	
Address		Address	
City/State/Zip		City/State/Zip	
Phone/Fax		Phone/Fax	
Relation to Patient		Relation to Patient	

☐ Information may be sent **and** received between the above two persons/organizations

Description of Information to be Released:

☐ Diagnosis	☐ Results of psychological/ vocational testing	☐ Other evaluations/ assessments:
☐ Psychiatric Evaluation	☐ Medical/neurological assessments, lab tests (EEG, EKG etc.)	
☐ Discharge Summary	☐ Verbal disclosure: treatment/hospital course	☐ Legal:
☐ Psychosocial Assessment	☐ Other:	
☐ Treatment Plan		☐ HIV test results **Patient must initial** _____
☐ Seclusion/Restraint information		
☐ Verbal notification: transfer to outside medical facility		

☐ **Release information from the time period:** _____ (date) **to** _____ (date)

OR

☐ **Release any of the above information, regardless of date**

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Confidential Patient Information
See W & I Code, Section 5328
HIPAA Privacy Rule CFR Section 164.508
DSH-5671 (Rev 12/15)

ADDRESSOGRAPH/LABEL

Purpose for Release of Information

☐ Evaluation ☐ Treatment Planning/Course ☐ Other: _____

I understand:

I am authorizing the release of (agreeing to share) my personal health information. When information is sent to/from a state hospital, the other person/organization will know that I have received mental health services.

I am signing this Authorization voluntarily (by my own choice- without force), and my treatment will not be affected if I do not sign this authorization.

The information released may be re-shared with others if it is allowed or required by law.

Reasonable fees may be charged to the person requesting the information, in order to cover the cost of copying and postage.

I have the right to receive a copy of this Authorization.

Prior to any release of information, I have the right to revoke this Authorization (change my mind and not allow information to be released). To revoke, I will send a written request to the Health Information Management Department (HIMD) at my facility or to a member of my treatment team. When HIMD/treatment team receives the request, they will not release any additional information.

If not revoked, this Authorization will expire at the end of:

☐ 6 months ☐ One year ☐ Other date: _____ ☐ Event: _____

Signature of Patient OR ☐ Parent/Guardian ☐ Conservator	Date
Printed Name	
Signature of Witness/Professional	Date
Printed Name	

ADDRESSOGRAPH/LABEL