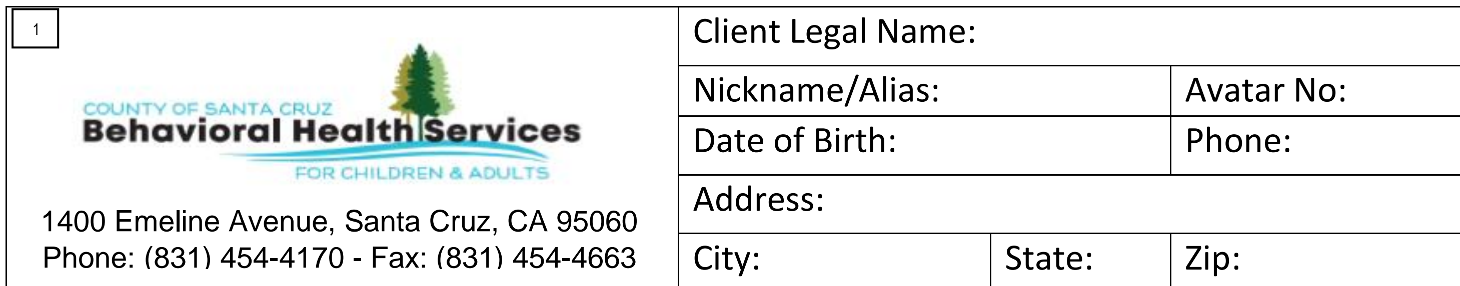

1 Behavioral Health Services — County of Santa Cruz — For Children & Adults 1400 Emeline Avenue, Santa Cruz, CA 95060 Phone: (831) 454-4170 - Fax: (831) 454-4663	Client Legal Name:		
	Nickname/Alias:		Avatar No:
	Date of Birth:		Phone:
	Address:		
	City:	State:	Zip:

2

HEALTH RECORDS RELEASE REQUEST to THIRD PARTY

I, ____ (Client Name or Legal Representative) authorize **Santa Cruz County Behavioral Health Services** to send specific Health Records to:

Entity Name: ____

Address: ____

Phone: _____________________ Fax: __________________ Email:____________________

3 **PURPOSE TO RELEASE RECORDS:** ☐ Client Request ☐ Treatment Planning ☐ Care Coordination ☐ Other (Specify reason):

4 I permit the release of the following Treatment Records: [Check appropriate boxes]:

☐ Mental Health Treatment: from _____________ to ___________

☐ Substance Use Disorder Treatment: from _____________ to ___________ **[Required]**

5 **RECORDS TO BE RELEASED** [Check all appropriate boxes or it will be excluded]:

☐ Diagnosis ☐ Evaluation/Assessment ☐ Treatment Plan ☐ General Progress Notes

☐ Medication List ☐ Psychiatry Progress Notes ☐ Treatment/Discharge Planning

☐ Drug / Alcohol Treatment Information (**Required** signer initials): __________

☐ HIV/AIDS Test Results or References (**Required** signer initials): ___________

☐ Other (explain): ____

6

METHOD TO RELEASE BEHAVIORAL HEALTH RECORDS:

☐ Fax ☐ US Postal Mail ☐ Encrypted Email ☐ Pick Up in Person

EXPIRATION: Authorization expires after records are released (no later than 15 business days of signature date). Future record releases require a separate authorized request.

7 **MY CLIENT RIGHTS: (1)** I may refuse to sign this authorization and no records will be released. My refusal will not affect my ability to obtain treatment or eligibility for benefits. **(2)** Substance Use Disorder Records are protected under federal confidentiality rules **(42 CFR Part 2 & CARES Act),** CARES ACT authorizes re-disclosure. **(3)** Health Records provided to someone not covered by **HIPAA** confidentiality laws (such as a family friend) may result in information re-disclosure by that person to someone else. **(4)** I may revoke this record release at any time prior to records being released by submitting a written request to: Quality Improvement, Medical Records, 1400 Emeline Avenue, Santa Cruz, CA 95060 to activate an effective revoke date. **(5)** I have the right to a copy of this form. ___________ (Initial that you have been offered a copy.)

[**FOR Children's Mental Health (CBH) staff (minor ownership)**: *My signature below confirms that I have assessed this 12-17 year old minor and determined the minor* ☐ *does* ☐ *does not have the capacity to authorize the release of her/their/his protected health information.].*__________________/_______

CBH Staff Signature/Date

Client/Legal Guardian Signature:	Date:

3rd Party Medical Records Release Form Instructions

1
- Please fill out client information in Box 1
- Behavioral Health Staff can help with the Avatar Number

2
- Client to enter PRINT name on the first line
- Recipient Name: Client to enter person's name or entity/organization and fill in address, phone, fax number and/or email address of entity who can **receive** treatment information.
  - If Client wants BHS SUDS staff to release records to BHS MH staff the Enter "MHP Behavioral Health Services"

3
- Check any box(s) that describes the purpose/reason for the release of this information

4
- Check the appropriate box(s) for type of medical records (Mental Health / Substance Use Disorder) you are permitting staff to release. Also what is the time range of authorized release of records?
  - Note that for Mental Health treatment entering a "From" and "To" Date is **optional**
  - Note that for Substance Use Disorder treatment information **requires** "From" and "To" date

5
- Check the appropriate box(s) that describes what medical records you are permitting staff to release.
- Check Other if no box is appropriate and write in specific information
- Note that for HIV / AIDS Test Results to be released you must initial the form and a separate authorization is required for each HIV / AIDS disclosure
- **Initial is required for Drug / Alcohol & HIV / AIDS information release**

6
- Check the appropriate box for how to release information to person/entity
- EXPIRATION: Authorization expires after records are released (no later than 15 business days of signature date). Future record releases require a separate authorized request.

7
- Your RIGHTS – Please read!
- You have a right to have a copy of this authorization. Please initial that you have been offered a copy
- If Client is a minor 12 years of age or older and wanting to complete form, then CBH staff box needs completion capacity determination and sign/date form before form is valid.

8
- Sign and date the release of information

9
- If you are not the client, describe your relationship to the client and legal authority to sign the form
- You may be required to provide legal paperwork

BH 27R_ 3rd Party Medical Records Release English Instructions