**AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION**

|  |  |  |
| --- | --- | --- |
| Client Name | DOB | SSN or Client ID |
| Client Parent/Guardian |  |  |

**I authorize WestCoast Children’s Clinic or the below named staff to share written and oral information (two-way or reciprocal release) about my needs and the services I receive:**

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| --- |
| WestCoast Children’s Clinic Staff: |
| Phone Number:                                                                              Fax: |
| Department: |

**With the following persons or facility:**

|  |
| --- |
| Individuals or Facility: |
| Address: |
| Phone Number:                                                                              Fax: |

**PURPOSE OF DISCLOSURE:**   
Treatment Coordination [ ] Transfer [ ] Legal [ ] Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SPECIFIC INFORMATION FOR DISCLOSURE:**  
Entire Record [ ] or Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Drug/Alcohol Abuse, Diagnosis, Treatment (42 CFR 2.34/2.35) Initial\_\_\_\_\_\_\_\_\_\_\_\_\_  
HIV/AIDS test results (HS 120980(g)) Initial\_\_\_\_\_\_\_\_\_\_\_\_\_  
Genetic Testing Information (HS 124980(j)) Initial\_\_\_\_\_\_\_\_\_\_\_\_\_

**Effective for dates covering \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and expiring \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (if no date is indicated, then authorization will expire twelve (12) months from effective date)**

**Limitations on Information to be shared: (attach additional sheet if nec.)**

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**NOTICE:** WestCoast Children’s Clinic and many other organizations and individuals such as physicians, hospitals, health plans, and social services are required by law to protect the confidentiality of your health information. **If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, state or federal laws may no longer protect it.**

**YOUR RIGHTS:** This Authorization to release health information is voluntary. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine any entity’s obligation to pay a claim, or (4) to create health information to provide to a third party. For more information, please refer to our Notice of Privacy Practices.

You may revoke this Authorization at any time. Your revocation must be made in writing, signed by you, or your representative, and delivered to: Director of Clinical Services, WestCoast Children’s Clinic, 3301 E. 12th Street, Suite 259, Oakland CA 94601.

The revocation will take effect when WCC receives it, except to the extent WCC or others have already released or shared information.

**You are entitled to a copy of this Authorization.**

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Printed Name Signature (Patient / Parent / Representative)  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date Relationship to Patient  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
WestCoast Children’s Clinic Staff Staff Signature

WCC ROI 3/14/2013