Exodus Recovery – Crisis Stabilization Center
4411 East Kings Canyon Road, Fresno, CA 93702

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

RESET

This Consent was interpreted in English-Spanish-Hmong for the client and/or responsible adult.
Interpreter Printed Name: _____
Signature: _____ **Date:** _____

Client First Name: _____ **Middle Name:** _____
Last Name: _____ **AKA(s):** _____
Date of Birth: _____ ID#: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____
Name of Guardian/Legal Representative (if applicable): _____
Relationship to client: _____

I authorize Exodus Recovery to:

☑ **Release Health Information To:** ☐ **Request Health Information From:**

Person / Organization: Fresno County Superintendent of Schools
Address: Judith Saldivar BHSL jsaldivar@fcoe.org
City / State / Zip: Fresno, CA
Phone: _____ Fax: _____

For the following purpose(s):

☑ Discharge Coordination ☐ Significant Support Person(s) Involvement ☐ Client Request
☑ Continuity of Care ☐ Legal ☐ Other: _____

Information to Release/Request

Treatment Dates: Current Admission

☑ Diagnosis ☐ Medication history/Current medication ☐ Prognosis
☐ Psychological/Psychiatric/Nursing evaluation(s)
☐ History/physical exams regarding medical/physical impairment(s)
☑ Discharge summaries and instructions ☐ Laboratory/Radiological data
☐ Progress notes, **(*excludes "psychotherapy notes" as defined in 45 CFR 164)**
☐ Entire Record *(Justify)*: _____
☐ Other *(Please Specify)* _____

A separate authorization is required for psychotherapy notes.

NOTE: Records may include information related to alcohol or drug use and HIV or AIDS. However, treatment records from drug and alcohol facilities or results of HIV test will not be disclosed unless specifically requested.

Please initial to request the applicable type of records be released:

_____ Alcohol/Drug Use treatment, evaluation(s), assessment(s), progress notes
_____ HIV test results

Method of Release

☐ Telephone communication ☐ In-person communication ☐ Fax of Health Information
☐ Physical copy of Health Information ☐ Inspection/Review of own Health Information
☑ Other: Secure email

Revised 01/01/21

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I understand the following rights and limitations:

1. **Refusal:** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain/maintain treatment.
2. **Scope: This authorization is limited to only that information that I have requested above to be used or disclosed to the persons/organizations named above.** I understand that this authorization may extend to records regarding my treatment, payment, hospitalization, and outpatient care for my impairment(s).
3. **Inspection:** I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
4. **Fees:** Based on California Evidence Code Sections 1560- 1567 Fees may be charged for medical record copies.
5. **Re-disclosure:** The information that is used or disclosed by this authorization may be re-disclosed and may no longer be protected by federal privacy regulations. However, any information disclosed to health care providers, insurance companies, and health plans will continue to be protected and not to be reused or re-disclosed other than as authorized by me or permitted by law.
6. **Revocation:** I have the right to revoke this authorization at any time, without it affecting my ability to obtain/maintain treatment, but must do so in writing, signed by me or on my behalf, and deliver or mail it to the address provided above.
   - If I revoke this authorization, it will not have any effect on any actions taken prior to Exodus Recovery receiving the revocation or on disclosures or usage that has already relied on this authorization to take an action or otherwise allowed by law.
7. **Copy:** I have the right to receive a copy of this authorization.
   I would like a copy: ☐ Yes ☐ No
8. **Expiration:** Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
   - If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed.

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

Signature: _____ **Date:** _____
(Client, Guardian, Power of Attorney for Healthcare or Legal Representative, etc.)

Witness/Staff Signature: _____ **Date:** _____

Witness/Staff Print Name: _____

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