COUNTY OF YOLO
HEALTH AND HUMAN SERVICES
25 North Cottonwood Street, Woodland, CA 95695
500 A Jefferson Blvd., West Sacramento, CA 95605
111 E. Grant Ave., Winters, CA 95694
600 A Street, Davis, CA 95616

AUTHORIZATION FOR RELEASE and/or EXCHANGE OF INFORMATION/RECORDS

I, the undersigned, hereby authorize voluntarily the agencies/organizations as initialed below, to release and/or exchange information pertaining to myself or my child(ren):

Name:	Date of Birth:	Name:	Date of Birth:
Name:	Date of Birth:	Name:	Date of Birth:
Name:	Date of Birth:	Name:	Date of Birth:

Initial	Agency/Provider	Initial	Agency/Provider
	Alta Regional		S.T.E.A.C.
	Shores of Hope		Wayfarer/Walters House
	Cache Creek Lodge		WIC/Nutrition
	Downtown Streets Team		Woodland Food Closet
	California Indian Manpower Association		Yolo Food Bank
	Fourth & Hope		Yolo County Health Department
	California Vocational Rehabilitation		Yolo County Housing
	Yolo County Children's Alliance/Children's Home Society		Yolo County Office of Education
	Communicare Health Centers, Peterson, Salud, John H. Jones or Davis Community Clinic		Residential Property Owner/Manager:
	Employment Development Department		Yolo County Probation Department
	Empower Yolo		Yolo Family Service Agency
	Health Care Provider/Clinic:		Other(s):
	Legal Services of Northern California		
	_____School or School District or Community College		☐ Declined to Consent

In order for Yolo County Health and Human Services Agency to develop a plan of comprehensive services for me or my child(ren), or both, I authorize the release and/or exchange of employment, educational, medical, mental health, substance abuse, domestic violence, housing, transportation, social services and life skills information concerning myself or my child(ren), or both, between the Yolo County Health and Human Services Agency and the individuals and/or agencies which I have initialed, or written in, on this form.

This authorization shall be effective when I sign it, and expires on _____ (not to exceed one [1] year). I may revoke/stop this authorization at any time by delivering a written revocation to Yolo County Health and Human Services Agency at one of its addresses given above. I may revoke/stop this authorization at any time in writing and it will be effective on that date, though not including information shared previous to that date.

Information disclosed by this authorization could be re-disclosed by the recipient and may no longer be protected by certain Federal confidentiality regulations (HIPAA). However, California law prohibits the person receiving my health information pursuant to this authorization from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

I understand that all information released or exchanged will be handled confidentially. I understand that I may give or refuse such authorization. I will not be denied services and/or treatment if I choose not to sign or revoke/stop this authorization. I understand that I have the right to receive a copy of this authorization. A telecopy transmission or photocopy of this form shall be as valid as the original.

AUTHORIZATION

Signature:_____ Date:_____

(Please circle one or more as applicable: Client/Parent/Legal Guardian)

☐ Client has been provided a copy of authorization.

Verification of identity of person authorizing release of information: _____

Verification of authority of person authorizing release of information: _____

Witness:_____ Date:_____