YOLO COUNTY
HEALTH & HUMAN SERVICES AGENCY
AUTHORIZATION FOR RELEASE OF CLIENT INFORMATION

Yolo County Health & Human Services Agency (HHSA) is an integrated agency includes Employment, Social Services, Alcohol and Drug, Mental Health, and Public Health. The goal of our integrated agency is to better serve our residents. Toward that end, different parts of HHSA seek your authorization to share your information in order to coordinate your care and better serve you.

Click Here for Form Instructions

Name of Client: _____ _____ **Date of Birth:** _____
First Name Last Name

Client Address: _____

City, State, Zip Code: _____ _____ _____
City State Zip

Description of Information to be Released

A. I authorize Yolo County Health & Human Services to release the following information:

☐ All information pertaining to my medical history, mental or physical condition and treatment received (this may include drug/alcohol and mental health information documented by a primary care physician), social services records, records of public benefits, vocational and other records of services received from Yolo County programs/agencies;

– OR –

☐ Only the following records or types of information (including any dates): _____

B. I specifically authorize release of the following information (check as appropriate and initial):

☐ Mental health treatment information _____ (initial)

☐ HIV test results _____ (initial)

☐ Alcohol/drug treatment information _____ (initial)

The Following Yolo County Programs/Divisions May Use, Receive, Disclose and Exchange My Records UNLESS Crossed Out

The **purpose** of this authorization is to allow the Yolo County programs/divisions listed below that are involved in my treatment and care, or in the provision of services to me, to use, disclose, and exchange information concerning me with each other to develop a plan of comprehensive services. I give my permission for the release and exchange of confidential information limited to and as necessary to accomplish this purpose by the sources listed below, UNLESS crossed out.

Adult Protective Services (APS)	Drug & Alcohol	Mental Health
In Home Support Services (IHSS)	Nurse Home Visiting	Homeless Services
California's Children's Services/ Medical Therapy Program (CCS)	Child Health & Disability Prevention Program (CHDP)	Medi-Cal, CMSP, CalFresh, CalWORKs, General Assistance
Child Welfare Services (CWS)	Women Infants Children (WIC)	Employment Services
Adolescent Family Life Program	Communicable Disease	Immunization
Fetal Infant Mortality Review/ Sudden Infant Death Syndrome (FIMR/SIDS)	Public Health	Vital Records
	Other: _____	

Expiration

This authorization expires on (date): _____ unless canceled earlier, except to the extent that action has already been taken in reliance upon on it. If no date is provided, this authorization will expire one year from the date it is signed.

My Rights

- Authorizing the disclosure of my records is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or to create health information to provide to a third party.
- I have a right to receive a copy of this authorization.
- I may inspect or obtain a copy of the information to be used or disclosed. Fees may be charged for copy costs.
- I have the right to cancel this authorization at any time by providing notice to HHSA canceling this authorization. Cancellation of this authorization will not apply to information that has already been released based on this authorization.
- Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law and federal drug and alcohol confidentiality laws prohibit the person receiving my health information 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.

Signature

I authorize the use or disclosure of the records described above for the purpose listed.

Date: _____

Signature: _____

(patient/legal representative)

If signed by a person other than the patient, indicate relationship: _____

Print name: _____

(legal representative)

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DESK PROCEDURE FOR COMPLETING THE AUTHORIZATION FOR RELEASE OF CLIENT INFORMATION

Description

HHSA provides services to residents of Yolo County through 4 branches, Adult & Aging, Children, Youth and Family, Community Health and Services Centers. In order to effectively collaborate across branches, while respecting clients' right to privacy and authorizing access to their personal information/records, HHSA will implement use of an internal AUTHORIZATION FOR RELEASE OF CLIENT INFORMATION (Internal Authorization). This Internal Authorization is for use between branches of HHSA only. Clients must sign separate release forms in order for any HHSA branch staff to share their information with an external entity.

Instructions

1. The form must have the Client's first and last name, date of birth and complete address. If a client reports they are homeless, the identified City where the person is currently reporting he/she is homeless should be listed.

2. Description of Information to be Released section, Part A, must have only ONE box checked. If the second box is checked, dates must be included. In Part B, ONE OR MORE of the boxes may be checked. If a box is checked, the client must also initial the line provided.

3. In the Purpose section of the Internal Authorization, all programs/divisions listed are assumed allowable UNLESS crossed out. The client must specifically line out any program for which they are not consenting to the sharing of their information between branches.

4. In the Expiration section, a date is not required. If left blank, the Internal Authorization is effective for one year from the date it is signed.

5. The section on Rights should be verbally reviewed with the client prior to their signature.

6. The Signature section must include both the date and signature to be valid.