Santa Clara Family Health Plan™

Authorization for Release of Mental Health and/or Substance Abuse Records

Name of Patient	Date of Birth	Social Security #

1. *I hereby authorize* _____ (M.D., agency or institution) to furnish medical information concerning MENTAL HEALTH AND SUBSTANCE ABUSE RECORDS INCLUDING OUTPATIENT TREATMENT WITH A PSYCHOTHERAPIST for the above patient to:

   _____
   (Name & address of receiving person, agency or institution)

2. *I authorize* the following information to be released:

   _____

3. *I authorize* that the information released may be used for only the following purposes:

   These records are to be used in conjunction with the independent medical review.

4. *I authorize* the following persons or entities to have access to the above information:

   _____
   (Name or function of the persons or entities authorized to have access to the above medical information)

5. *I understand* the length of time the information will be kept is until _____ (date). I understand that this information and all copies will be properly destroyed OR returned before or immediately after this date. This time frame may be extended provided I am notified and authorize the extension, the use of the information, who will have access to it, and when the information and all copies will be properly destroyed or returned.

6. This authorization to release records is effective _____ (today's date), and the authorization will remain effective for sixty (60) days from this date.

7. *I understand* that I will receive a copy of this authorization within thirty (30) days informing me of receipt of the information requested, and that the receiving person/entity will not further release these records without my additional consent.

8. *I understand* that the information will not be used for any purpose other than its intended use as noted above.

Patient's Signature: _____ **Date:** _____

NOTE: For alcohol and substance abuse patient records, state law requires signature by the parent/guardian/conservator AND the minor.

Parent/Guardian/Conservator Signature: _____

Please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian/conservator of an incompetent patient
- ☐ Beneficiary/personal representative of deceased patient

(Pursuant to Civil Code Section 56.104 and Evidence Code 1010, Title 42, Code of Federal Regulations)