

**Santa Barbara County Public Health Department
Health Information Management**

Authorization for Use or Disclosure of Health Information

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization or limit our ability to respond to your request.

PLEASE PRINT

Patient Name: _____ Other Name(s): _____

Date of Birth: _____ Social Security #: _____

I hereby authorize:

Santa Barbara County Health Care Center Outside Provider

Name and Address

Area Code – Telephone

To disclose information about my health to:

Physician/New Doctor Insurance
 Attorney Self
 Santa Barbara County/WIC
 Other _____

Send this information to the following address:

Name/Company

Street Address and City / P.O. Box

State Zip Code Area Code – Telephone

Please forward the following information:

- | | |
|--|---|
| <input type="checkbox"/> Evaluation, Progress Notes/Doctor Notes | <input type="checkbox"/> Baseline H&P |
| <input type="checkbox"/> X-ray Films and/ or Reports | <input type="checkbox"/> Consultation / Referral Report |
| <input type="checkbox"/> Laboratory and Pathology Reports | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Other _____ | |

ONLY the following medical records or types of health information, including any dates
(Describe):

Information to disclose (if not signed and checked, these will not be released):

I understand that by signing this form, I am specifically authorizing the release of information relating to:

- Minor's family planning and pregnancy information
- Substance abuse (alcohol or drug abuse records)
- Human Immunodeficiency Virus (HIV) related information including AIDS related testing
- Behavioral Health

The confidentiality of this record is required under Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in this statute.

Signature

Date

This release applies to information from: _____ to: _____

Restrictions: Please do not send the following (information or time period covered):

This authorization will be valid for twelve (12) months from signature date unless it is revoked by the patient in writing.

You have the right to revoke (withdraw) this authorization at any time by submitting a signed written request to: Santa Barbara County, Health Care Center (see address below). Your revocation will be effective upon receipt, but will not be effective to the extent that actions to comply with the original request have already been taken, or if the authorization was obtained as a condition of obtaining insurance coverage.

I understand that I have a right to receive a copy of this release upon my request.

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits 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 of Patient/Parent/Guardian/Personal Representative:

_____ Date: _____

Print Name: _____

HEALTH CARE CENTERS

Carpinteria Health Care Center
931 Walnut Ave
Carpinteria, CA 93013
805 560-1050

Franklin Health Care Center
1136 E Montecito St.
Santa Barbara, CA 93013
805 568-2099

Lompoc Health Care Center
301 N "R" St.
Lompoc, CA 93436
805 737-6400

Santa Barbara Health Care Center
345 Camino Del Remedio
Santa Barbara, CA 93110
805 681-5488

Santa Maria Health Care
2115 S Centerpointe Parkway
Santa Maria, CA 93455
805 346-7230