CONTRA COSTA HEALTH SERVICES
- **CONTRA COSTA SUBSTANCE ABUSE**
- **CONTRA COSTA MENTAL HEALTH**
- **CONTRA COSTA REGIONAL MEDICAL CENTER**
- **CONTRA COSTA HEALTH CENTERS**

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

PATIENT NAME: FIRST / MIDDLE / LAST		DATE OF BIRTH		RECORD #
AKA (OTHER NAME)				
STREET ADDRESS	CITY	STATE	ZIP	AREA CODE / PHONE #

I am the ☐ **PATIENT** ☐ **GUARDIAN** ☐ **CONSERVATOR** ☐ **DESIGNEE** and hereby authorize Contra Costa Health Services to disclose medical records for the above named patient to:

SEND TO (NAME OF PERSON, ORGANIZATION, AGENCY)				
STREET ADDRESS	CITY	STATE	ZIP	AREA CODE / PHONE #
PURPOSE: THE DISCLOSURE OF THESE RECORDS IS FOR THE FOLLOWING PURPOSE(S) ONLY:				
VISIT or ADMISSION / DISCHARGE DATES OR OTHER DATES FOR PURPOSE OF THIS INFORMATION RELEASE				

RESTRICTIONS: I understand that the recipient of this information **may not** further use, transfer nor redisclose the medical information to any person or entity unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

INFORMATION TO BE RELEASED: This authorization is for **full disclosure of all records**, including Clinical Findings, Diagnosis, Treatment, Assessment, Recommendations for Further Care, Names of Health Care Personnel, Dates of Hospitalizations and Ambulatory Visits, Charges, and any information which may be related to Drug, Alcohol, or Psychiatric conditions or treatment and/or Sexually Transmitted Disease, including AIDS and HIV Test Result information. Such records will be disclosed unless you specify information you wish excluded. Please initial below information you do not want released:

_____ No Exclusions
INITIAL

Exclude:

_____ Exclude HIV test results
INITIAL

_____ Exclude Substance Abuse information
INITIAL

_____ Exclude Psychiatric information
INITIAL

_____ Exclude other information: ______________________________
INITIAL SPECIFY

DURATION: This authorization shall become effective immediately and shall remain in effect for one year or until ____________________, whichever comes first. This consent is also subject to revocation by the undersigned at any time between now and the release of information by the sending person, agency, or institution.

RIGHT TO A COPY OF AUTHORIZATION: I understand that I have a right to receive a copy of this authorization.

Please take a copy after signing. ☐ **YES,** I have taken my signed copy of this form.

DATE	PATIENT SIGNATURE		SIGNATURE OF HOSPITAL STAFF WHEN REQUIRED (AB610, MENTAL HEALTH)	
SIGNATURE OF PARENT, GUARDIAN, CONSERVATOR, DESIGNEE		RELATIONSHIP	EMPLOYEE NAME	DATE

A photocopy of this release is as valid as the original.