

**AUTHORIZATION FOR RELEASE OF INFORMATION**

YOUR INFORMATION			
Last Name:	First Name:	Middle Name:	Date of Birth
Street Address:		City/State/Zip:	CDCR/YA #:

Person/Organization Providing the Information	Person/Organization to Receive the Information
<input checked="" type="checkbox"/> <b>California Prison Health Care Services</b> Name: _____ Address: _____ City/State/Zip _____ Phone # : ( _____ ) _____ Fax number: ( _____ ) _____	<input type="checkbox"/> <b>California Prison Health Care Services</b> Name: <u>RECORDS DEPOSITION SERVICE, INC.</u> Address: <u>P.O. BOX 5054</u> City/State/Zip <u>SOUTHFIELD / MI / 48086-5054</u> Phone # : ( <u>248</u> ) <u>357</u> <u>3330</u> Fax number: ( <u>248</u> ) <u>357</u> <u>3337</u>
[45 C.F.R. § 164.508(c)(1)(iii) & Civ. Code § 56.11(e), (f).]	

Description of Information to be Released (Provide a detailed description of the specific information to be released) [45 C.F.R. § 164.508(c)(1)(i) & Civ. Code § 56.11(d) & (g).]					
<input type="checkbox"/>	Medical	<input type="checkbox"/>	Mental Health	<input type="checkbox"/>	Genetic Testing
<input type="checkbox"/>	Dental	<input type="checkbox"/>	Substance Abuse/ Alcohol	<input type="checkbox"/>	Communicable Disease
<input type="checkbox"/>	HIV	<input type="checkbox"/>	Psychotherapy Notes	<input checked="" type="checkbox"/>	Other (Please specify below:)
PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST					
For the following period of time: from _____ (date) to _____ (date)					

Description of Purpose for the Use or Release of the Information Indicate how information is to be used. [45 CFR. § 164.508(c)(1)(iv).]			
<input type="checkbox"/> Health Care	<input type="checkbox"/> Personal Use	<input checked="" type="checkbox"/> Legal	
<input type="checkbox"/> Other (Please specify: _____)			

**Will the health care provider receive money for the release of this information?**  
[45 C.F.R § 164.524(c)(4)(i), (ii).]

Reasonable fees may be charged to cover the cost of copying and postage.

This authorization for release of the above information to the above-named persons/organizations will expire on: \_\_\_\_\_ (date).  
[45 C.F.R. § 164.508(c)(1)(v) & Civ. Code § 56.11(h).]

I understand that:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary. [45 C.F.R. § 164.508(c)(2)(i).]
- I have the right to revoke this authorization by sending a signed notice stopping this authorization to the Health Records department at my current institution. The authorization will stop further release of my health information on the date my valid revocation request is received in the Health Records department. [45 C.F.R. § 164.508(c)(2)(i) & Civ. Code § 56.15.]
- I am signing this authorization voluntarily and that my treatment will not be affected if I do not sign this authorization. [45 C.F.R. § 164.508(c)(2)(ii).]
- Under California law, the recipient of the protected health information under the authorization is prohibited from re-disclosing the information, except with a written authorization or as specifically required or permitted by law. (Civ. Code § 56.13)
- If the organization or person I have authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. [45 C.F.R. § 164.508(c)(2)(ii).]
- I have the right to receive a copy of this authorization. [45 C.F.R. § 164.508 (c)(4) & Civ. Code § 56.11(i)]

<b>Signature:</b>	<b>CDCR/YA Number:</b>	<b>Date:</b>
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[45 C.F.R. § 164.508 (c)(vi) & Civ. Code § 56.11(c)(1)]

<b>Representative:</b>	<b>Relationship:</b>	<b>Date:</b>
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[45 C.F.R. § 164.502 (g)(1) & Civ. Code § 56.11(c)(2)]