Riverside-San Bernardino County Indian Health, Inc.
Authorization for Release, Use or Disclosure of Protected Health Information Behavioral Health Services (BHS)

I. Patient Legal Name:	M.I.	Last Name:
Other Name:		Date of Birth:
Address:	City:	State:
Zip Code:	Telephone:	Email:

I authorize Riverside San Bernardino County Indian Health, Inc., to ☐ Request from or ☐ Release to the below Recipient or Facility name; Selected protected health information (PHI)

II. Recipient Name or Facility Name: _____
Address:_____City: _____State: _____Zip: _____
E-mail Address:_____ Phone: _____
Facility Fax Number:

III. Patient's protected health information is being released, used, or disclosed for the following Purpose(s) of disclosure: _____

IV. I authorize the following personal health Information to be used or disclosed:

◯ Behavioral Health Treatment ◯ Alcohol, Drug, or Substance Abuse Records

- ☐ PsychiatricEvaluation
- ☐ Therapy Notes
- ☐ Treatment Plan
- ☐ Provider Summary
- ☐ Provider Letter
- ☐ HIV Test/Results
- ☐ Drug Test/Results
- ☐ Billing Records
- ☐ Other specify: _____

Covering the period from Specific Date(s):____ /____/____ through _____/____ /____

I understand that the information in my behavioral health record may include information relating to Alcohol, drug or substance use testing and results, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

☐ Yes ☐ No Date(s): _____ Alcohol, Drug, or Substance Use Records
☐ Yes ☐ No Date(s): _____ HIV Testing and Results
☐ Yes ☐ No Date(s): _____ Genetic Testing

Disclosure Format (Paper is default if not marked.)

- ☐ In-Person Pick-up
- ☐ Personal Representative
- ☐ Patient Portal
- ☐ U.S. Certified Mail - Paper
- ☐ E-mail Encrypted (unsecure format, i.e., Gmail, Yahoo)
- ☐ CD/Flash drive-secure format
- ☐ Other (Please specify):_____

By signing this authorization form, I understand that I have the following rights with Respect to this Authorization:

I may not be required to sign this Authorization as a condition to obtaining treatment, payment, enrollment or eligibility for benefits. RSBCIHI will provide me with a copy of this Authorization. I may inspect or obtain a copy of the information to be used or disclosed. I have the right to access my own records and request corrections if I believe the information is incorrect or incomplete. The recipient of the protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law.

For Alcohol Drug or Substance Use records 42 CFR part 2 prohibits unauthorized disclosure of these records. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I have the right to revoke this authorization at any time.
Revocation must be made in writing and presented or mailed to the **Health Information Management Department at: 11980 Mount Vernon Ave Grand Terrace, CA 92313.** Revocation will not apply to information that has already been disclosed in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition ____/____/____If I fail to specify an expiration date, event or condition, this authorization will expire upon its completion or 12 months from the date of signature.

Requests for copies of medical or behavioral health records are subject to reproduction fees in accordance with federal/state regulations. Marketing and Sale of PHI is not applicable.

A copy of this Authorization is valid as an original.
In consideration of such use, or disclosure, I hereby release you (in your individual or institutional capacity) from any and all liability arising from the use, or disclosure of otherwise confidential information.

By signing this form, I, _____authorize Behavioral Health Services (BHS) to release my health information to the recipient or Facility listed on this

form for the purposes of coordination of care, treatment planning, or as otherwise required by law.

This authorization is subject to the following conditions:

Provider Approval: Information will only be released upon approval by BHS Director or treating provider, and the release is to facilitate proper care and services or as otherwise required by law.
Right to Decline Release: I understand that the BHS Director or treating provider has the right to decline the release of information if it is determined that disclosing my health information may result in harm to my well-being, or may negatively impact my treatment and recovery process.
Specific Information: The information to be disclosed may include (but is not limited to) diagnosis, treatment plans, progress notes, and other medical records relevant to my behavioral health and alcohol, drug, and substance use records.

By signing below, I acknowledge that I understand the nature of this release, the provider's right to decline disclosure in order to prevent harm, and the approval process by the provider.

Patient or (if Patient is a Minor) Signature	Date	Time
Print Patient Name or Legal Representative	Indicate Legal Authority	
Parent or Legal Representative Signature	Date	Time
Witness Signature (If Sensitive Information is disclosed)	Date	Time

For Office Use Only	
Please return completed form to HIM or BHS department at: **San Manuel Indian Health Clinic** **HIM Department** **11980 Mount Vernon Ave.** **Grand Terrace CA 92313**	HIM Email: HIM@rsbcihi.org HIM eFax: (909) 907-7930 **MRN**: _____ **Date of Birth:** _____ /_____ /_____ **Date Form Received:**_____/_____/_____ **Date Records Sent:** _____/_____/_____
Print Full Name of Person Approving The Form	**Department:**