AUTHORIZATION FOR
CONTRA COSTA HEALTH SERVICES
MENTAL HEALTH DIVISION

TO RECEIVE MEDICAL AND
MENTAL HEALTH INFORMATION

TO:

REPLY TO MEDICAL RECORDS AT:

☐ **Central County Adult Mental Health**
1420 Willow Pass Rd., Ste. 200
Concord, CA 94520
Ph. 925-646-5480
Fax 925-646-5622

☐ **Older Adult Mental Health**
2425 Bisso Lane, Suite 100
Concord, CA 94520
Ph. 925-521-5620
Fax 925-521-5639

LISTED BELOW ARE PROGRAM AT THE SAME ADDRESS:

☐ **Children's Mental Health Services**
2425 Bisso Lane, Suite 200
Concord, CA 94520

☐ **Central County Child & Adolescent Mental Health**
Ph. 925-646-5468
Fax 925-646-5102

☐ **EPSDT/Emergency Foster Care/TBS Services**
Ph. 925-521-5740
Fax 925-646-5810

☐ **Hospital and Residential Program**
Ph. 925-521-5700
Fax 925-646-5662

☐ **MH/CFS**
Ph. 925-521-5720
Fax 925-646-5810

Re:______________________________ DOB ____________

MR# ______________ AKA ______________________________

To enable the Contra Costa Health Services facility indicated at the left to provide continuing care and coordinate and monitor treatment for the above-named individual, I hereby authorize you to release to that indicated facility: clinical findings, diagnoses, surgeries, treatments, diagnostic test results, assessments, and recommendations for further care, including any information which may be related to drug, alcohol or psychiatric conditions, or information pertaining to sexually transmitted diseases, including AIDS and HIV test result information.

_____ I make **NO** exclusions.
INITIAL

_____ Exclude releasing the following information ______________________
INITIAL

Dates of services requested ______________________________

Specific data requested ______________________________

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RE-DISCLOSURE I understand that Contra Costa Health Services 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.

DURATION This Authorization is effective immediately and will remain in effect for one year or until (date/event) ______________, whichever comes first. I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the address indicated at the left. My revocation will be effective upon receipt, but will not be effective to the extent that you or Contra Costa Health Services has acted in reliance upon this Authorization.

RIGHTS I understand that I have a right to receive a copy of this authorization. I may refuse to sign this authorization. Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this Authorization.

Date ______________ Signature ______________________________

If signed by Representative, indicate relationship ______________________

Original Addressee
Yellow Medical Records
Pink Patient