suda CENTERS

Suda Centers, Inc.

Section 235 – Attachment A

CONSENT TO RELEASE CONFIDENTIAL HEALTH INFORMATION

Client's Name:	DOB:

I, *(Name of Client)* _____ and/or

(Parent/Legal Guardian/Conservator) _____ authorize

(Releasing Agency) Kaiser Permanente to disclose to

(Receiving Agency/Person) _____ *(Address)* _____
the following information with the knowledge such release discloses the fact that the named person has received mental health services.

The disclosure shall be limited to the following specific information (*Nature and amount of information to be disclosed; as limited as possible to accomplish the stated purpose or intended use*):

___Diagnosis
___Summary of psychological and psychiatric history
___Medical information including the results of medical tests
___Other: _____

___ Results of psychological and vocational tests
___ Legal status
___ Educational assessment and behavioral reports (including school observation and educational testing)

This disclosure of the above-mentioned specific mental health information is required for evaluation, treatment or for the following purpose (*Indicate, as specific as possible, the purpose and use of the disclosure*): _____
_____

I understand that: 1) My mental health records are protected under the California Welfare and Institutions Code (WIC) and the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. The exceptions are set forth in the *Notice of Privacy Practices*; 2) I may revoke my consent by providing a written notice withdrawing my consent; and 3) If the program has already disclosed information in reliance on my consent, the program is not required to try to retrieve that information.

If not earlier revoked, this consent shall automatically terminate and expire on or as follows (*Give date, event or condition, upon which this consent expires*):_____
If I do not write in a date, it will expire 12 months from the date it was signed.

Client's Signature _____ Date_____

Parent/Legal Guardian/Conservator's Signature_____ Date_____

MENTAL HEALTH USE ONLY

I, the physician, licensed psychologist, or social worker with a masters degree in social work, or marriage and family therapist, who is in charge of the client, hereby ☐ **Approves** ☐ **Disapproves** the release of information and records to receiving agency or person. If disclosure is disapproved, give reasons below. (No approval is required for release to client's attorney.)

_____
_____

Date	Physician/Psychologist/Social Worker/Marriage Family Therapist	Credential