Authorization to Release Protected Health Information to Identified Family/Support Members

Purpose Statement: Behavioral Health and Recovery Services (BHRS) encourage clients to include family in their treatment planning. Family is support people, friends and significant others. Family Partnership is an important element of recovery from mental illness.

Name (*print*):	Date of Birth: _____/_____/_____ *month day year* Client Number:

Authorization: I understand that by signing this authorization form attachment, at my request I authorize (BHRS) my provider to release specific information to the following individuals:

(Client to initial in the box to the left of each person's name to confirm that the client authorizes the release of information):

Initial	Name	Code	Phone Number	Address	Relationship to Client

The release of information is limited to the minimum necessary and applies to the following codes. If no code is specified, then all codes below should apply*:*

1. To schedule and/or confirm appointments
2. To confirm whether or not I am attending appointments and/or whether or not I am in a particular mental health program
3. To participate in periodic treatment planning meetings and to be kept informed of any modification(s) to my periodic treatment plan
4. Other _____

Name (*print*):	Date of Birth: _____/_____/_____ *month day year* Client Number:

RE-USE OF INFORMATION: I understand that if I authorize the release of my health information to someone who is not legally required to keep it confidential, that information may be shared with others and may no longer be protected. I also understand that under no circumstances am I required to authorize the release of psychotherapy notes.

CONDITIONS: I understand that I do not have to sign this Authorization form. I understand that treatment, payment, enrollment and eligibility for benefits will not be based on my signing or refusing to sign this authorization, except if treatment is related to research, or if health care services are given to me only for creating protected health information for release to a third party.

RIGHT TO TAKE BACK AUTHORIZATION: I understand that I have the right to take back my authorization. If I take back my authorization, I have to notify the County in writing, I have to sign the notice, and I have to deliver the notice to the County at the following address**: Behavioral Health and Recovery Services, Department of Health and Human Services, 250 Bon Air Road Unit B, Greenbrae, CA 94904.**

My revocation will take effect upon receipt, except to the extent that others have acted in reliance on this authorization.

EXPIRATION: This authorization will go into effect immediately and will remain in effect until _____ (write in date). If I do not write in a date, this authorization will remain in effect for one year from the date of my signature.

Signature (*Client or Representative, as appropriate*)*:	Date (*month/day/year*):
** If form is signed by someone other than the client, state the relationship to client,* Name (*print*): _____ Relationship: _____	
Name of County Representative Who Receives this Form *(Print*):	Date (*month/day/year*):