

**If you need your records by a particular date,
Please note it here: _____**

**AUTHORIZATION FOR RELEASE OF MEDICAL OR MENTAL HEALTH
INFORMATION**

Name _____ Date of Birth _____

Phone _____ Address _____

City _____ State _____ Zip code _____

NOTICE: Santa Barbara Behavioral Health (SBBH) and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS: This authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) solely to create health information to provide to a third party. This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to SBBH, 5901 Encina Rd, Suite A, Goleta, CA 93117. The revocation will take effect when SBBH receives it, except to the extent SBBH or others have already relied on it. **You are entitled to receive a copy of this Authorization.**

PLEASE: Complete the following form for your medical records request and submit both pages to:

**SANTA BARBARA BEHAVIORAL HEALTH
5901 Encina Road, Suite A
Goleta, CA 93117
PHONE: 805.681.0035 FAX: 805.681.0029**

I AUTHORIZE:
(Person or facility which has health information)

TO RELEASE INFORMATION TO:
(Person or facility to receive health information)

Name _____

Name _____

Address: _____

Address: 5901 Encina Road, Suite A
Goleta, CA 93117

Phone: _____

Phone: (805) 681- 0035

Fax: _____

Fax: (805) 681- 0029

Type of disclosure: Verbal Information Copies of records

Please specify the health information you authorize to be released:

- Mental health information (Subject to the Lanterman-Petris-Short Act, Welf. & Inst. Code 5000 et seq)
- Drug and alcohol abuse, diagnosis or treatment information subject to federal law (42 C.F.R 2.34 and 2.35)
- Medical (This may include drug/alcohol and mental health information documented by a primary care practitioner or other medical specialist)
- Lab Reports
- Progress reports for the last year of treatment

Type(s) of information, if not specified above (e.g. Summary, Report, Letter):

Specify date(s) of treatment, time period or condition: _____

Limitations upon disclosure: _____

The purpose of this release is:

- Coordination of care with _____
- At the request of the client/patient/patient representative
- Other (state reason) _____

EXPIRATION OF AUTHORIZATION:

Unless otherwise revoked, this authorization expires one year after the date signed.

Print Name

Phone Number

Patient Signature

Guardian/Patient Representative's Name

Date

Guardian/Patient Representative's
Signature

Release Received by: _____