Date:_____

AUTHORIZATION FOR RELEASE OF MEDICAL OR MENTAL HEALTH INFORMATION

Name: _____ Date of Birth: _____

Phone: _____ Address: _____

City**:** _____ State: _____ Zip**:** _____

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

NOTICE: 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 Road, Ste 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.**

I AUTHORIZE:	**TO RELEASE INFORMATION TO:**
(Person or facility which has health information)	**(Person or facility to receive health information)**
Name:_____	Name: _____
Address: **5901 Encina Road, Suite A**	Address:_____
Goleta, CA 93117	_____
Phone: **(805) 681- 0035**	Phone :_____
Fax: **(805) 681-0029**	Fax: _____

☐ If you are requesting that medical records be sent to **yourself or another individual** (not a doctor or facility), please provide an email address so that we may send them electronically: _____

Date:_____

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

Please specify the health information you authorize to be released:

☐ Verbal Information (please specify):

- ☐ Scheduling and cancelling appointments
- ☐ Treatment information, including diagnosis & medications

☐ Copies of progress notes

(Includes mental health information subject to the Lanterman-Petris-Short Act, Welf. & Inst. Code 5000 et seq; medical information; drug and alcohol abuse, diagnosis or treatment information subject to federal law 42 C.F.R 2.34 and 2.35)

Type(s) of information, if not specified above (e.g. report, letter, document):

_____

_____

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