Alameda County Behavioral Health Care Services
MENTAL HEALTH & SUBSTANCE USE SERVICES

Alameda County Behavioral Health Care Services (ACBHCS)
2000 Embarcadero Cove, Suite 400 O a k l a n d , California 94606

AUTHORIZATION TO DISCLOSE PSYCHOTHERAPY NOTES

PATIENT INFORMATION

Last Name **First Name** **Middle Initial** **Date of Birth**

Street Address **City** **State** **Zip Code**

Home Phone **Work Phone** **Client ID #**

I HEREBY AUTHORIZE THAT MY PSYCHOTHERAPY NOTES BE RELEASED FROM:

Physician/Clinic/Hospital/Other Name

Address **City/State** **Zip Code** **Phone Number**

I HEREBY AUTHORIZE THAT MY PSYCHOTHERAPY NOTES BE RELEASED TO AND USED BY:

Physician/Clinic/Hospital/Other Name

Address **City/State** **Zip Code** **Phone Number**

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INFORMATION REQUESTED

For Dates of Service: From: To:

I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization and that I am entitled to receive a copy of this authorization and want and have received such a copy. Y ☐ N ☐

EXPIRATION: This Authorization expires twelve (12) months from:

PURPOSE OF TRANSFER OF RECORDS

Permanent Transfer ☐ Referral ☐ Other: ☐

Some types of information relating to your mental health treatment are entitled to a higher level of protection than ordinary mental health or medical records. For these kinds of information, state and/or federal law require the patient, guardian, or authorized representative to provide a separate authorization before they may be released to and/or used by others. These include psychotherapy notes, which are notes taken by treating clinicians about the patient. These notes may include your statements, summaries of your statements, and/or analyses and conclusions based on your confidential conversations with your treating clinicians and caseworkers.

***By signing, I specifically authorize the release and use of psychotherapy notes in my records*.**

Signature of Patient **Print/Type Name** **Date**

Signature of Parent/Guardian **Print/Type Name** **Date**

REVOCATION: I understand that I have a right to revoke this authorization at any time unless action has been taken in response to or in reliance on this authorization. I understand that my revocation must be in writing and presented to an ACBHCS Health Information representative in order to revoke the authorization granted to ACBHCS. I further understand that I must present a separate written revocation to any other person or entity that I have authorized to receive or use my psychotherapy notes above in order to revoke the authorization granted to that person or entity.

WARNING: PROHIBITIONS ON USAGE, TRANSFER OR REDISCLOSURE OF INFORMATION, except as required by State or Federal laws, use of information released for other than the stated purpose, or redisclosure or transfer of this information to any person or entity not named herein is PROHIBITED. An additional written authorization must be obtained for any proposed new use of the information or for its redisclosure or transfer of such information. The information disclosed may be subject to redisclosure and would no longer be protected by federal privacy regulations.

MEDICAL RECORDS WILL BE RETAINED FOR TEN (10) YEARS FOLLOWING A PATIENT'S DISCHARGE FROM OUR AGENCY, WHEREUPON THEY WILL EITHER BE DESTROYED OR, IF REQUESTED, RETURNED.