Mendocino County Health and Human Services Agency
"Healthy People, Healthy Communities"
Tammy Moss Chandler ❖ HHSA Director

Behavioral Health and Recovery Services
Jenine Miller, Psy.D., BHRS Director
Providing Mental Health Services

***Ukiah Offices*: 1120 S. Dora St. • Ukiah • CA • 95482 • (707) 472-2300 • FAX (707) 472-2306**
***Fort Bragg Offices*: Avila Center • 790-B S. Franklin St. • Fort Bragg • CA • 95437 • (707) 961-2665 • FAX (707) 961-2698**
***Willits Integrated Services Center*: 474 E. Valley St. • Willits • CA • 95490 • (707) 456-3850 • FAX (707) 456-3808**

AUTHORIZATION TO RELEASE OR RECEIVE CONFIDENTIAL INFORMATION

Client Name: _____ DOB: _____ Record # _____

AKA/Parent/Legal Guardian Name:_____

I am the ❑ **Client** ❑ **Legal Guardian** ❑ **Conservator**

I AUTHORIZE RECORDS/INFORMATION
____ TO BE SENT TO: _____

Address: _____ City: _____ Zip: _____

I AUTHORIZE RECORDS/INFORMATION
____ TO COME FROM: _____

Address: _____ City: _____ Zip: _____

_____ I AUTHORIZE EXCHANGE OF INFORMATION between the above parties.

The above information is to include:
❑ Records subject to the Lanterman-Petris-Short Act (Psychiatric) ❑ Medical Information.

Please (specify): _____

You have the right to exclude certain types of information. Please exclude: _____

_____

Purpose of records needed:

_____

(*If purpose not specified the release may not be honored)*

I understand that the requester may not further disclose this information unless another authorization is obtained from me, or unless such disclosure is required or permitted by law.

This authorization is subject to revocation by the undersigned at any time, and if not earlier in writing, it shall terminate one year from the date signed below.

❑ **RIGHT TO A COPY OF AUTHORIZATION:** I understand that I have a right to receive a copy of this authorization. ❑ **Yes**, I was offered a copy of this form.

Client Signature: _____ Date: _____

Witness: _____ Date: _____

Signature of Parent, Legal Guardian, Conservator: _____

Relationship: _____

If this consent is signed by the client and the release requires concurrence by the provider, provider must sign below?

Mental Health Provider Signature: _____

Degree: _____ Date: _____

A photocopy of facsimile of this release is as valid as the original. Sender of records keeps the original copy.