# AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

TO: Sanctuary Psychiatric Centers of Santa Barbara

P.O. Box 551

Santa Barbara, CA 93102

I authorize you to release any or all medical or treatment information contained in the record of:

_____, Date of Birth: _____,

*Self/name of person and relationship*

Social Security No.: _____, for the period from: _____ to present,

TO: _____

_____

_____

This information is required to assist in my future placement/admission and assess the type of services needed. All facilities will maintain and use the information in strict compliance with all applicable laws governing medical privacy, including but not limited to the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the California Confidentiality of Medical Information Act and the Lanterman-Petris-Short Act. This authorization will expire within one year of the date below unless otherwise specified here: _____.

- ☐ a. medical records (most recent physical exam., TB test)
- ☐ b. psychiatric evaluation (diagnosis, medications)
- ☐ c. testing
- ☐ d. admissions summary
- ☐ e. departure summary (if applicable)
- ☐ f. coordinated care plan
- ☐ g progress notes (most recent)
- ☐ h. other: _____

_____

The following boxes above have been checked:_____

_____ _____

*Patient Signature/authorized representative signature* *Date*

_____ _____

*Witness* *Date*