


<div style="display: flex; align-items: center;"> <div style="margin-right: 20px;"> <p>Santa Cruz County Behavioral Health</p> <p>1400 Emeline Avenue, Santa Cruz, CA 95060 bhrecordrequest@santacruzcountyca.gov</p> </div>  </div>	Client Legal Name: _____		
	Nickname/Alias: _____		Avatar No: _____
	Date of Birth: _____		Phone: _____
	Address: _____		
	City: _____	State: _____	Zip: _____

2 HEALTH RECORDS RELEASE REQUEST to THIRD PARTY DATE: _____

I, _____ (Client Name or Legal Representative)
 authorize **Santa Cruz County Behavioral Health Services** to send specific Health Records to:
 Entity Name: _____
 Address: _____
 Phone: _____ Fax: _____ Email: _____

3 PURPOSE TO RELEASE RECORDS: Client Request Treatment Planning
 Care Coordination Other (Specify reason): _____

4 I permit the release of the following Treatment Records: [Check appropriate boxes]:

Mental Health Treatment: from _____ to _____
 Substance Use Disorder Treatment: from _____ to _____ **[Required]**

5 RECORDS TO BE RELEASED [Check all appropriate boxes or it will be excluded]:

Diagnosis Evaluation/Assessment Treatment Plan General Progress Notes
 Medication List Psychiatry Progress Notes Treatment/Discharge Planning
 Drug / Alcohol Treatment Information (**Required** signer initials): _____
 HIV/AIDS Test Results or References (**Required** signer initials): _____
 Other (explain): _____

6 METHOD TO RELEASE BEHAVIORAL HEALTH RECORDS:

Fax US Postal Mail Encrypted Email Pick Up in Person

EXPIRATION: Authorization expires after records are released (no later than 15 business days of signature date). Future record releases require a separate authorized request.

7 MY CLIENT RIGHTS: (1) I may refuse to sign this authorization and no records will be released. My refusal will not affect my ability to obtain treatment or eligibility for benefits. **(2)** Substance Use Disorder Records are protected under federal confidentiality rules (**42 CFR Part 2 & CARES Act**), CARES ACT authorizes re-disclosure. **(3)** Health Records provided to someone not covered by **HIPAA** confidentiality laws (such as a family friend) may result in information re-disclosure by that person to someone else. **(4)** I may revoke this record release at any time prior to records being released by submitting a written request to: Quality Improvement, Medical Records, 1400 Emeline Avenue, Santa Cruz, CA 95060 to activate an effective revoke date. **(5)** I have the right to a copy of this form. _____ (Initial that you have been offered a copy.)

[FOR Children’s Mental Health (CBH) staff (minor ownership): My signature below confirms that I have assessed this 12-17 year old minor and determined the minor does does not have the capacity to authorize the release of her/their/his protected health information.]. _____ / _____
 CBH Staff Signature/Date

Client/Legal Guardian Signature: _____	Date: _____
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Send records requests to: bhrecordrequest@santacruzcountyca.gov or
 SCBH Custodian of Records, 1400 Emeline Bldg. K Santa Cruz, CA 95060

3rd Party Medical Records Release Form Instructions

- | | |
|---|--|
| 1 | <ul style="list-style-type: none">• Please fill out client information in Box 1• Behavioral Health Staff can help with the Avatar Number |
| 2 | <ul style="list-style-type: none">• Client to enter PRINT name on the first line• Recipient Name: Client to enter person's name or entity/organization and fill in address, phone, fax number and/or email address of entity who can receive treatment information.<ul style="list-style-type: none">○ If Client wants BHS SUDS staff to release records to BHS MH staff the Enter "MHP Behavioral Health Services" |
| 3 | <ul style="list-style-type: none">• Check any box(s) that describes the purpose/reason for the release of this information |
| 4 | <ul style="list-style-type: none">• Check the appropriate box(s) for type of medical records (Mental Health / Substance Use Disorder) you are permitting staff to release. Also what is the time range of authorized release of records?<ul style="list-style-type: none">○ Note that for Mental Health treatment entering a "From" and "To" Date is optional○ Note that for Substance Use Disorder treatment information requires "From" and "To" date |
| 5 | <ul style="list-style-type: none">• Check the appropriate box(s) that describes what medical records you are permitting staff to release.• Check Other if no box is appropriate and write in specific information• Note that for HIV / AIDS Test Results to be released you must initial the form and a separate authorization is required for each HIV / AIDS disclosure• Initial is required for Drug / Alcohol & HIV / AIDS information release |
| 6 | <ul style="list-style-type: none">• Check the appropriate box for how to release information to person/entity• EXPIRATION: Authorization expires after records are released (no later than 15 business days of signature date). Future record releases require a separate authorized request. |
| 7 | <ul style="list-style-type: none">• Your RIGHTS – Please read!• You have a right to have a copy of this authorization. Please initial that you have been offered a copy• If Client is a minor 12 years of age or older and wanting to complete form, then CBH staff box needs completion capacity determination and sign/date form before form is valid. |
| 8 | <ul style="list-style-type: none">• Sign and date the release of information and submit it to: bhrecordrequest@santacruzcountyca.gov or SCBH Custodian of Records: 1400 Emeline Bldg. K, Santa Cruz, CA 95060 |
| 9 | <ul style="list-style-type: none">• If you are not the client, describe your relationship to the client and legal authority to sign the form• You may be required to provide legal paperwork• Send/Deliver completed 27R form to QI Medical Records. Enter date submitted & person's name |

BH 27R_ 3rd Party Medical Records Release English Instructions