AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize the Department of Health Care Services to release
(Name of Patient)

the materials used in my Community-Based Adult Services (CBAS) assessment materials to the

Adult Day Health Care (ADHC) center _____ that I am currently enrolled in.
(Name of ADHC center)

This information may include information on mental health, alcohol and/or drug treatment and sexually transmitted diseases or HIV/AIDS. This information will only be used to help me get medical care and services that I may need. All health information will be kept private and will not be released unless authorized or required by law.

I understand that by signing this authorization:

- I authorize the use or disclosure of my health information, including information on mental health, alcohol or substance abuse and HIV/AIDS, as described above for the purpose listed.
- This authorization is valid for one year from the date of signature.
- I am signing this authorization voluntarily. I can withdraw this authorization at any time.
- I understand that withdrawing my authorization will not be effective where the Department of Health Care Services has already acted on my authorization in good faith.
- I understand that my treatment, payment, and eligibility for Medi-Cal benefits will not be affected if I do not sign this authorization.
- I also understand that the ADHC cannot further disclose my information unless another authorization is obtained from me or unless such disclosure is required or permitted by law.

_____ _____
Print Name of Beneficiary Medi-Cal Number

_____ _____
Signature of Beneficiary or Legal Representative Date

Legal Authority:

☐ Legal Guardian/Custodian. Attach a copy of proof of guardianship.

☐ Healthcare Power of Attorney. Attach a copy of power of attorney.

CONFIDENTIAL