STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
AUTHORIZATION FOR RELEASE OF INFORMATION
CDA 9009 (REV 11/2023)

☐ CBAS	☐ HICAP	☐ MSSP	☐ OSLTCO

Your Information

Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:

Person/Organization Providing the Information	**Person/Organization Receiving the Information**
Name: _____	Name: _____
Position or Role: _____	Position or Role: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Phone #: (_____) _____	Phone #: (_____) _____
Fax #: (_____) _____	Fax #: (_____) _____

45 C.F.R. §§ 164.508(c)(1)(ii), and (iii); CA Civil Code §§ 56.11(e), and (f)

Description of the Information to be Released
(Provide a detailed description of the specific information to be released)
45 C.F.R. § 164.508(c)(1)(i); CA Civil Code §§ 56.11(d), and (g)

Check each type of confidential information you authorize to be released:

☐ HIV or AIDS Information	☐ Alcohol/Drug Information
☐ Mental Health/Behavioral Health Information	☐ Genetic Testing
☐ Psychotherapy Records	☐ Developmental Records

Other:

For the following period of time from to .

Description of the Purpose and Limitations for the Use or Release of the Information
(Indicate how information will be used)
45 C.F.R. § 164.508(c)(1)(iv); CA Civil Code § 56.11(g)

The information will not be used for any purpose other than its intended use.

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Will the health plan or provider receive money for the release of this information? 45 C.F.R. § 164.524(c)(4)
☐ Yes ☐ No
Reasonable fees may be charged to cover the costs of copying and postage.

This authorization for release of the above information to the above named persons or organizations will expire on:_____ (date).
(45 C.F.R. § 164.508(c)(v); CA Civil Code § 56.11(h).)

I understand that:

- I authorize the use and/or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary. *(45 C.F.R. § 164.508(c)(2)(i).)*
- I have the right to revoke this authorization at any time by sending a signed notice stopping this authorization to _____ at_____. The authorization will cease on the date my valid revocation request is received. *(45 C.F.R. § 164.508(c)(2)(i); CA Civil Code § 56.15)*
- The Notice of Privacy Practices provides instructions for me should I choose to revoke my authorization and includes limitations on my revocation. *(45 C.F.R. § 164.508(c)(2)(i).)*
- My treatment, payment, enrollment or eligibility for benefits will not be affected if I do not sign this authorization. *(45 C.F.R. § 164.508(c)(2)(ii).)*
- Under California law, the recipient of my medical information is prohibited from re-disclosing the information, except with a written authorization or as specifically required or permitted by law. *(CA Civil Code § 56.13)*
- If the organization or person I have authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. *(45 C.F.R. § 164.508(c)(2)(iii).)*
- I have the right to receive a copy of this authorization. *(45 C.F.R. § 164.508(c)(4); CA Civil Code § 56.11(i).)*
- Records and copies obtained relating to outpatient psychotherapy care shall be returned or destroyed at the expiration date of this authorization except those obtained for treatment and diagnosis purposes. (CA Civil Code § 56.104(a)(4).)

Patient Signature:	Date:

(45 C.F.R. § 164.508(c)(1)(vi); CA Civil. Code § 56.11(c).)

Patient's (Personal) Representative Signature:	Relationship:	Date:

(45 C.F.R. § 164.508(c)(1)(vi); CA Civil Code § 56.11(c).)