AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I,____("Patient"), authorize

____
(Name of person or facility which has information)

to release information to:

Santa Clara Police Department Phone: (408) 615-4700

Address: 601 El Camino Real, Santa Clara, California 95050

The Santa Clara Police Department requests the following information: ___________________________

____

____

for the purpose of aiding first responders and law enforcement respond and interact with Patient in the event of an emergency or other contact.

This authorization shall expire upon the release of the records requested.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purposes listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Signed by Patient:	Date
Or Signed by Personal Representative: On Behalf of: Relationship to Patient:	Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Process / Psychotherapy Notes

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Re-disclosure Statement: **Must accompany all signed consent forms**

Prohibition on Re-disclosure of Confidential Information

This statement accompanies a disclosure of confidential health care information concerning a person and made to you with the consent of the person named.

State and federal laws, including The Health Insurance Portability and Accountability Act of 1996, HIPAA, 45 C.F.R., Parts 160 and 164, and the Federal Law of Confidentiality for Alcohol and Drug Abuse Patients, 42 C.F.R., Part 2, protects the privacy of health care information and requires patient consent prior to disclosing protected information.

The **state and federal rules prohibit you from making any further disclosure of this information** unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by state law, 45 C.F.R. Parts 160 and164 or 42 C.F.R, Part 2. **A general authorization** for the release of medical information **is not sufficient for this purpose**.

The state and federal rules restrict any use of the information to criminally investigate or prosecute any patient.