Central Coast Behavioral Health Inc.
536 Camino Mercado ▫ Arroyo Grande, CA 93420
Tel (805) 540-0279 ▫ Fax (805) 439-1070
centralcoastbehavioralhealth.com
ccbh-slo.com

HIPAA Release Form

Name: _____ DOB: _____

Address:_____

I hereby authorize Central Coast Behavioral Health Inc. for purpose of:
____ Ongoing Treatment / Aftercare; ____ To coordinate treatment efforts with family or concerned others,
____ Other: _____

____ Release medical records to: ____ Obtain medical records from:
____ Discuss with: ____ Both release medical records to and discuss with:

Name: _____ Address: _____

City or Town _____ State/Zip _____

The following information: ____ All information: including history, dates, course and outcome of treatment
____ Only the following information which is circled:

a. Discharge Summary	d. Medical H & P	g. Progress Notes
b. Medical Consultation	e. Psychiatric Evaluation	h. Outpatient Record
e. Diagnostic tests	f. Psychosocial Evaluation	i. Other records: _____

____ I DO ____ I DO NOT authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse. I understand that it cannot be re-disclosed by a recipient without specific consent.
____ I DO ____ I DO NOT authorize disclosure of information which refers to treatment or diagnosis of psychiatric illness.
____ I DO ____ I DO NOT wish to review such information prior to its release (the review may be supervised).
____ I DO ____ I DO NOT authorize disclosure of information which refers to treatment or diagnosis of HIV infection, ARCS or AIDS.

I understand that individuals about whom such disclosures have been made encountered discrimination from others in the areas of employment, housing, education, life insurance, health insurance, and social and family relationships.
I understand that: I can refuse to disclose some or all of he information in my treatment records, but if I do so, it could result in an improper diagnosis or treatment, denial of coverage, or a claim for health benefits or other insurance or other adverse consequences. I can revoke all or part of this authorization, in writing, at any time by delivering a written, dated and signed notification to the office of Dr. Guimaraes. I am entitled to a copy *of* this authorization, upon request. I can cross out any provision on this form with which I disagree. This authorization is effective until _____ (date not to exceed one (1) year), and I authorize future disclosures regarding these records m the same individuals and or entities during this time period.

_____ _____
Signature of Patient or Authorized Representative Print Name and Capacity

_____ _____
Signature of Witness and Print Name Date