



The First 5 years.  
Make them count.

**AUTHORIZATION FOR USE AND DISCLOSURE OF  
PROTECTED HEALTH INFORMATION PURSUANT TO HIPAA**  
(Medical, Mental Health, and Drug and Alcohol Treatment Records)

*This authorization pertains to records for the following individual:*

_____	_____
<b>Print Name</b>	<b>Date of Birth</b>
_____	
<b>Address</b>	
_____	_____
<b>Telephone Number</b>	<b>Other Identifiers</b>

I, (name) \_\_\_\_\_ authorize the organizations listed below to disclose the information specified below to **FIRST 5 Santa Clara County and its partner agencies**. Because this authorization discloses the fact that \_\_\_\_\_ received treatment from each provider listed below, I further authorize all organizations listed below to disclose to all other named organizations in this authorization the fact that \_\_\_\_\_ received treatment from them.

_____	_____
<b>Patient/Representative Signature</b>	<b>Date</b>
_____	_____
<b>Print Name</b>	<b>Telephone Number</b>
_____	
<b>Address</b>	

**For legal representative only:**

I \_\_\_\_\_ (print name) am legally authorized to execute this authorization form on behalf of the individual named above because I am the:

- \_\_\_\_ Parent of Minor
- \_\_\_\_ Foster Parent (H&S Code section 1530.6)
- \_\_\_\_ Legal Guardian
- \_\_\_\_ Conservator

**PURPOSE:** The person/organization who receives the health information can use it to coordinate benefits and services for the above named individual through FIRST 5 programs and compile data required for FIRST 5 outcome measures and State reporting.

The information may include but not be limited to: Assessment and Screening results; psychological and psychiatric history, treatment and diagnosis; medical information including tests results and diagnosis; educational assessment and behavioral reports; drug and alcohol treatment.

**DURATION:** This authorization is valid on the date it is executed and will remain valid for three years from that date unless it is earlier revoked by me or until an earlier date designated in the following space \_\_\_\_\_(date).

**REVOICATION:** I understand that I have a right to revoke this authorization at any time except to the extent that the program or person who is to make the disclosure has already acted in reliance on it. A revocation (1) must be in writing, (2) sent or given to FIRST 5, or to the treatment provider directly, and 3) is effective when it is received by the treatment provider. Once revoked, no further disclosures may be made of your protected health information.

**CONDITIONS:** I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on my giving or refusing to give this authorization, except if my treatment is related to research, or if health care services are given to me only for creating protected health information for release to a third party. I also understand that I may refuse to sign this authorization.

I understand that I have right to receive a copy of this authorization form if I request a copy. I also understand that information disclosed pursuant to this authorization is subject to re-disclosure by the recipient and may no longer be protected by Federal and State confidentiality laws.

**Medical Treatment Providers** (name/address/telephone number):

\_\_\_\_ **1. Santa Clara Valley Medical Center**

Records Requested:  
Dates of Records:  
Medical Record Number:

\_\_\_\_ **2. Santa Clara County Public Health Department**

Records Requested:  
Dates of Records:  
Medical Record Number:

\_\_\_\_ **3. Other Health care organization (private physician)**

Records Requested:  
Dates of Records:  
Medical Record Number:

\_\_\_\_ **4. \_\_\_\_\_**

Records Requested:  
Dates of Records:  
Medical Record Number: