UNIVERSAL RELEASE OF INFORMATION (URI)

Completion of this document authorizes the use, disclosure, and exchange of health information about you. Failure to provide all information requested may invalidate this authorization.

Client Name:

DOB:	**Client Number:**

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the individuals/agencies listed and initialed below to use, disclose, or exchange health information.

To release to Persons / Organizations	**Address** *(street, city, state, zip code)*	**Initial**
California Department of Rehabilitation		
California Tribal TANF Partnership		
Child and Family Services (CaFS) - GCOE		
Dentist(s):		
Doctor(s):		
Far Northern Regional Center		
First 5 Glenn County		
Glenn County Dept. of Child Support Services		
Glenn County HHSA – Child Welfare Services		
Glenn County HHSA – Drug and Alcohol Programs		
Glenn County HHSA – Mental Health Programs		
Glenn County HHSA – Other: Division _____ and Program _____		
Glenn County HHSA – Public Assistance Programs		
Glenn County HHSA – Public Health Programs		
Glenn County Office of Education (GCOE)		
Glenn County Probation Department		
Glenn County Superior Court/Treatment Court		
Glenn Medical Center/Children's Center		
Hospital(s):		
Northern Valley Indian Health		
Rape Crisis Intervention and Prevention		
School District(s):		
Other:		
Other:		
Other:		

The following information:

a. ☐ All health information pertaining to my medical history, mental or physical condition and treatment received; OR
   ☐ Only the following records or types of health information (including any dates): _____

b. I specifically authorize release of the following information (check as appropriate):
   ☐ Mental health treatment information[1]
   ☐ HIV test results
   ☐ Alcohol/drug treatment information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

PURPOSE

Purpose of requested use or disclosure: ☐ Client request; OR ☐ Other:

EXPIRATION

This authorization expires on (date):

[1] If the client requests that mental health information covered by the Lanterman-Petris-Short Act be released to a third party, the physician, licensed psychologist, social worker with a master's degree in social work or marriage and family therapist who is in charge or the client must approve the release. If the release is not approved, the reasons therefore should be documented. The client could most likely obtain a copy of the record himself or herself and then provide the records to the third part, however.

MY RIGHTS

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.[2]

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing[3] and submit it to the following address:

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this information.

I have a right to receive a copy of this authorization.[4]

Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

If this box ☐ is checked, the Requestor will receive compensation for the use or disclosure of my information.[5]

SIGNATURE

Date:	**Time:** ☐ AM / ☐ PM
Signature:	
(client/legal representative)	
If signed by someone other than the client, indicate relationship:	
Printed Name:	
(legal representative)	

[2] If any of the HIPAA recognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the provision of an authorization. A covered entity is permitted to condition treatment, health plan enrollment, or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

[3] Clients of federally-assisted substance abuse programs and clients whose records are covered by LPS may revoke an authorization verbally.

[4] Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (see 45 C.F.R. Section 164.508 (d)(1), (e)(2)).

[5] The requestor is to complete this section of the form.