AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

CDCR 7385 (Rev. 10/19)

All sections must be completed for the authorization to be honored. Use "N/A" if not applicable.

I. Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

CDCR# _____ Date of Birth: _____

Street Address: _____ City/State/Zip: _____

II. Individual/Organization Authorized to Release Personal Health Records if Other Than CDCR

Name: _____

Address: _____ City/State/Zip: _____

III. Individual/Organization to Receive the Information

[45 C.F.R. § 164.508(c)(1)(ii), (iii) & Civ. Code § 56.11(e), (f)]

The undersigned hereby authorizes CDCR's Health Information Management to release the health information pursuant to this authorization.

Name: Kern County District Attorney's Office

Relationship to Patient: District Attorney Phone: (661) 868-2340 Fax: (661) 868-2700

Address: 1215 Truxtun Ave. City/State/Zip: Bakersfield, CA 93301

IV. Authorization Expiration Event or Expiration Date for Release of Verbal Information/ Written Correspondence

[45 C.F.R. § 164.508(c)(1)(v) & Civ. Code § 56.11(h)]

Unless otherwise revoked by the patient, this authorization for the release of health care information to the above-named individual/organization will expire on the date specified below, event identified, or 12 months from the date signed in Section IX, whichever occurs first:

Date of Expiration: _____ Event: 1170(d) review completed; no more than1 yr from receipt of rec.

From (mm/dd/yyyy): _____ To (mm/dd/yyyy): _____

V. Health Care Records to be Released - General

[45 C.F.R. § 164.508(c)(1)(i) & Civ. Code § 56.11(d), (g)]

I authorize records for the following period of time to be released (must be completed to receive records):

From (mm/dd/yyyy): Date of incarceration (DOI) To (mm/dd/yyyy): Present day

☐ Medical Services ☐ Dental Services ☑ Other: Psychotherapy notes

NOTE: Health records released as part of this authorization may contain references related to mental health, substance use disorder, medication assisted treatment, genetic testing, communicable disease, and HIV medical conditions.

VI. Health Records to be Released - Specify

[45 C.F.R. § 164.508(c)(1)(i) & Civ. Code § 56.11(d), (g)]

☐ Communicable Disease Records from _____ to _____ Signature: _____ Date: _____

☐ Genetic Testing Records from _____ to _____ Signature: _____ Date: _____

☐ HIV Test Results from _____ to _____ Signature: _____ Date: _____

☐ Medication Assisted Treatment Records from _____ to _____ Signature: _____ Date: _____

☐ Mental Health Treatment Records from _____ to _____ Signature: _____ Date: _____

☐ Substance Use Disorder Records from _____ to _____ Signature: _____ Date: _____

NOTE: Health records released as part of this authorization may contain references related to dental, medical, mental health, substance use disorder, medication assisted treatment, genetic testing, communicable disease, and HIV conditions.

Requests for psychotherapy notes require a separate CDCR 7385 and may not be combined with any other request for health records.

☑ Psychotherapy Notes

Unauthorized collection, creation, use, disclosure, modification or destruction of personally identifiable information and/or protected health information may subject individuals to civil liability under applicable federal and state laws.

All sections must be completed for the authorization to be honored. Use "N/A" if not applicable.

VII. Purpose for the Release or Use of the Information

[45 C.F.R. § 164.508(c)(1)(iv)]

☐ Health Care ☐ Personal Use ☑ Legal ☑ Other (please specify): PC 1170(d) resentencing request/review

VIII. Authorization Information

I understand the following:

1. I authorize the use or disclosure of my individually identifiable protected health information as described above for the purpose listed. I understand this authorization is voluntary.

2. I have the right to revoke this authorization. To do so I understand I can submit my request in writing to my current institution's Health Information Management (health records). The authorization will stop further release of my protected health information on the date my valid revocation request is received by Health Information Management. [45 C.F.R. § 164.508(c)(2)(i)]

3. I am signing this authorization voluntarily and understand that my health care treatment will not be affected if I do not sign this authorization. [45 C.F.R. § 164.508(c)(2)(ii)]

4. Under California law, the recipient of the protected health information under the authorization is prohibited from re-disclosing the protected health information, except with a written authorization or as specifically required or permitted by law. [Civ. Code § 56.13]

5. If the organization or person I have authorized to receive the protected health information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations.[45 C.F.R. § 164.524(a)(2)(v)]

6. I have the right to receive a copy of this authorization. [45 C.F.R. § 164.508(c)(4) & Civ. Code § 56.11(i)]

7. Reasonable fees may be charged to cover the cost of copying and postage related to releasing this protected health information. [45 C.F.R. § 164.524(c)(4) et seq. & California Health and Safety Code § 123110, et seq.]

8. I understand that my substance use disorder records are protected under the federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R., Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be redisclosed without my written consent unless otherwise provided for by the regulations.

IX. Patient Signature

[45 C.F.R. § 164.508(c)(1)(vi) & Civ. Code § 56.11(c)(1)]

Name: (Print): _____

Signature: _____ Date: _____

If no expiration date is specified in section IV, this authorization will expire 12 months from this date.

Name of person signing form, if not patient (Print): _____

Signature: _____ Date: _____

Describe authority to sign form on behalf of patient: _____

Name of translator/interpreter assisting patient, if applicable (Print): _____

Signature of translator/interpreter: _____ Date: _____

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Instructions

Note: Part IV is the request for release of verbal health care information or health care information as part of written correspondence, and Part V is the request for release of health care records.

Part I - "Patient Information": Records the patient's full name (last, first, and middle), CDCR number, date of birth, and address if he/she is paroled or released (incarcerated patients do not need to provide an address).

Part II - "Individual/Organization Authorized to Release Personal Health Records if Other Than CDCR": Records the name and address of the individual or organization authorized to release personal health records if other than CDCR.

Part III - "Individual/Organization to Receive the Information": Records who is to receive the information.

Part IV - "Authorization Expiration Event or Expiration Date for Release of Verbal Information/Written Correspondence": Used by the patient to limit the time period during which information may be shared.

- The patient may enter the date he/she wants the authorization to expire.
- The patient may enter an expiration event.
- The patient may enter a date range of information to be shared.
- If no expiration date is specified, this authorization is good for 12 months from the date signed in Section IX.

Part V - "Health Care Records to be Released - General": Contains a designated line for the date range of health care records to be released.

- **"Medical Services"** is checked when the patient wishes to have information released related to medical care.
- **"Dental Services"** is checked when the patient wishes to have information released related to dental treatment.
- **"Other"** is checked when the patient wishes to further restrict or further authorize the release of his/her medical information, and he/she is to write those wishes on the line provided.

Part VI - "Health Records to be Released - Specify": Health care information in this section requires a date range, additional signature, and signature date.

- **"Communicable Disease"** is checked when the patient wishes to have information released related to communicable disease testing and treatment. Communicable disease includes sexually transmitted infections.
- **"Genetic Testing"** is checked when the patient wishes to have information released related to genetic testing.
- **"HIV Test Results"** is checked when the patient wishes to have HIV test results released.
- **"Medication Assisted Treatment Records"** is checked when the patient wishes to have information related to medication assisted treatment released.
- **"Mental Health Treatment Records"** is checked when the patient wishes to have information released related to mental health treatment.
- **"Substance Use Disorder Records"** is checked when the patient wishes to have information related to substance use disorder treatment released.
- **"Psychotherapy Notes"** is checked when the patient wishes to have psychotherapy notes released. Requests for psychotherapy notes require a separate CDCR 7385 and **may not be combined with any other request for health care records.**

Under HIPAA, there is a difference between regular personal health information and psychotherapy notes. The following is HIPAA's definition of psychotherapy notes (§164.501):

Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

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Instructions (continued)

Part VII - "Purpose for the Release or Use of the Information": Should have at least one box checked. The patient may utilize this section to check the provided boxes or select "Other" and describe the reason(s) he/she wants to have the information released. If the patient does not want to designate a purpose, he/she may check the "Other" and state "At the request of the individual authorizing the release."

Part VIII - "Authorization Information": Below this section are eight points which detail patient rights in regards to authorizing release of information.

1. Tells the patient that he/she is giving authorization voluntarily.
2. Explains how to stop this authorization. The patient may revoke the authorization by submitting his/her request in writing to his/her institution's Health Information Management. The authorization will be removed from the patient's medical record when the revocation is received by Health Information Management.
3. Explains that signing this authorization is voluntary and will not affect treatment.
4. Explains that the recipient of the protected health care information under the authorization is prohibited from re- disclosing the information, except with a written authorization from the patient or as specifically required under law.
5. Explains that the released information may no longer be protected by federal privacy regulations depending on the intended recipient of the released information.
6. Explains that the patient has the right to receive a copy of this authorization. This will be sent to the patient by Health Information Management.
7. Explains that reasonable fees may be charged to cover copying and postage costs related to releasing the patient's health information.
8. Explains that substance use disorder records are protected and cannot be disclosed without the patient's written consent unless otherwise provided for by the regulations.

Part IX - "Patient Signature": The bottom of page two is for the patient's, his/her representative's, or the translator/interpreter's signature. The patient's printed name, signature, and date are to be entered in the boxes provided. If this authorization is completed by a patient representative (e.g., power of attorney, estate representative, next of kin), his/her printed name, relationship to patient, signature, and date are to be entered in the boxes provided. Also attached must be a copy of either the Power of Attorney, letters issued in estate proceeding, or declaration of next of kin. If an interpreter/translator assisted the patient in filling out this form, his/her printed name, signature, and date are to be entered in the boxes provided.

Unauthorized collection, creation, use, disclosure, modification or destruction of personally identifiable information and/or protected health information may subject individuals to civil liability under applicable federal and state laws.