AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

CDCR 7385 (Rev. 11/14)

<u>All sections</u> 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 below health information pursuant to this authorization.

Name: ________________________________ Relationship to Inmate: __________________

Address: ______________________________ City/State/Zip: _________________________

Phone: ________________________________ Fax: ___________________________________

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 inmate, this authorization for the release of my health care information to the above-named person or organization will expire upon (choose one):

☐ Date (mm/dd/yyy): _________________________ ☐ Release from Custody

☐ Happening/conclusion of this event: ____

(e.g., conclusion of litigation, completion of surgery)

V. Hardcopy Health Care Records to be Released

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

A separate authorization is required for each request to release hardcopy records. Records for the following period of time are requested (must be completed to receive records):

☐ From (mm/dd/yyyy): ______________________ To (mm/dd/yyyy): ______________________

☐ Medical Services ☐ Dental Services ☐ Mental Health Services

☐ Communicable Disease ☐ Genetic Testing ☐ HIV Test Results

☐ Substance Abuse/Alcohol ☐ Other: ____

Requests for Psychotherapy Notes require a separate CDCR 7385 in order to be fulfilled and <u>may not be combined with any other request for health care records.</u>

☐ Psychotherapy Notes

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

VI. 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): ______________________________

VII. 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 sign a cancellation notice and send it 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.]

VIII. Patient Signature

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

Name (Print): ______________________________

Signature: ______________________________ Date: ______________

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 paper 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 to Release Personal Health Records if Other Than CDCR": Records the name and address of the individual or organization 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 selects one of the three check boxes.

- If the "Date" check box is selected, the patient enters the date he/she wants the authorization to expire.
- If the "Happening/conclusion of this event" check box is selected, the patient enters the event he/she wants the authorization to expire upon. This must be an event from which a date can be established.

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

The bottom half contains nine check boxes. Patients check the boxes to release each specific type of information as detailed below:

- **"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.
- **"Mental Health Services"** is checked when the patient wishes to have information released related to mental health.
- **"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.
- **"Substance Abuse/Alcohol"** is checked when the patient wishes to have substance abuse/alcohol records released.
- **"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.
- **"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.

Instructions (continued)

Part VI - "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" box and state "At the request of the individual authorizing the release."

Part VII - "Authorization Information": Below this section are seven points which detail patient rights in regard 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 sending a notice stopping the authorization to the 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.

Part VIII - "Patient Signature": The bottom of page two is for the patient's or his/her representative'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 and 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.