

DEPARTMENT OF HEALTH & HUMAN SERVICES
DEPARTAMENTO DE SALUD Y SERVICIOS HUMANOS

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION
AUTORIZACION PARA ENVIAR INFORMACION CONFIDENCIAL

Patient's name:
Nombre del Paciente

Also known as: Birthdate:
Conocido tambien como Fecha de nacimiento Mes/ Dia/ Año

I AUTHORIZE THE RELEASE OF INFORMATION FOR THE PURPOSE OF:
AUTORIZO LA ENTREGA DE INFORMACION CON EL PROPOSITO:

- Determination/review of eligibility for Mental Health Services
Coordination of Client Services
Facilitation of case planning
Other

- FROM WCMH TO THE PARTY NAMED BELOW
DE WCMH A LA ENTIDAD INDICADA ABAJO
TO WCMH FROM THE PARTY NAMED BELOW
A WCMH DE LA ENTIDAD INDICADA ABAJO

NAME OF FACILITY (Physician, clinic, hospital, attorney, etc.) PHONE NUMBER FAX NUMBER
NOMBRE DE LA INSTITUCION (Doctor, clinica, hospital, abogado, etc.) NUMERO DE TELEFONO NUMERO DE FAX

SENDING FACILITY'S ADDRESS, CITY, STATE, ZIP CODE
DIRECCION DE LA INSTITUCION, CIUDAD, ESTADO, CODIGO POSTAL

INFORMATION THAT MAY BE RELEASED:
INFORMACION QUE SE PUEDE ENVIAR:

- Psychological/Psychiatric Evaluations
Special Education Eligibility/IEP/Education records
Alcohol/Drug history & treatment records
Medical & Treatment Records including hospital(s)
Other specific information as indicated

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used and/or disclosed under this authorization. My consent may be revoked at any time; the only exception is when the action has already occurred as instructed in the consent. This consent will expire one year after the date of signature. I understand that if my information is released to an entity not covered by federal privacy regulation it may be redisclosed. A copy of this form shall have the same validity as the original.

Puedo negarme a firmar este consentimiento. Lo cual no afectara mi habilidad para obtener tratamiento o pago o elegibilidad de beneficios. Puedo inspeccionar o copiar cualquier informacion usada y/o enviada por esta autorizacion. Puedo revocar mi consentimiento en cualquier momento. La unica excepcion seria si la accion ya hubiera ocurrido como dicho en el consentimiento. Este consentimiento se vencera dentro de un ano de la fecha de la firma. Yo entiendo que si mi informacion es enviada a alguna entidad que no este regida por regulaciones federales de privacidad podria ser revelada. Una copia de este formulario tiene la misma validez como el original.

Signature: Date: Relationship:
Firma (Parent, Guardian, or Legal Representative) Fecha Mes Dia Año Parentesco (Padre, Guardian, o Representante Legal)

WITNESS: Patient has read or has had read to him/her the above information . Signature Date