# AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

TO: CUSTODIAN OF RECORDS OF

_____
Name of Holder of Records (e.g., physician, referring agency, etc.)

_____
Street Address

_____
City, State, Zip Code

I authorize you to release any or all medical or treatment information contained in the record of:

_____, Date of Birth: _____,
*Self/name of person and relationship*

Social Security No.: _____, for the period from: _____ to present,

TO: Sanctuary Centers of Santa Barbara
P.O. Box 551
Santa Barbara, CA 93102

This information is required to assist Sanctuary Centers in determining admission to the program and/or type of services needed. Sanctuary Centers will maintain and use the information in strict compliance with all applicable laws governing medical privacy, including but not limited to the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the California Confidentiality of Medical Information Act and the Lanterman-Petris-Short Act. This authorization will expire within one year of the date below unless otherwise specified here: _____.

- ☐ a. medical records (most recent physical exam., TB test)
- ☐ b. psychiatric evaluation (diagnosis, medications)
- ☐ c. testing
- ☐ d. admissions summary
- ☐ e. departure summary (if applicable)
- ☐ f. coordinated care plan
- ☐ g. verbal exchange of information (in person or by telephone)
- ☐ h. other: _____

The following boxes above have been checked:_____

_____ _____
*Patient Signature/authorized representative signature* *Date*

_____ _____
*Witness* *Date*