

AUTHORIZATION FOR RELEASE OF INFORMATION

YOUR INFORMATION

Last Name:	First Name:	Middle Name:
Address:	City/State/Zip:	CDC/YA Number:

Person/Organization Providing the Information [45 C.F.R. § 164.508(c)(1)(ii) & Civ. Code § 56.11(e).]	Person/Organization to Receive the Information [45 C.F.R. § 164.508(c)(1)(iii) & Civ. Code § 56.11(f).]
CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION	

Description of the Information to be Released (Provide a detailed description of the specific information to be released.) [45 C.F.R. § 164.508(c)(1)(i) & Civ. Code §§ 56.11(d) & (g).]						
<table style="width: 100%;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Medical</td> <td style="width: 50%;"><input type="checkbox"/> Substance Abuse</td> </tr> <tr> <td><input type="checkbox"/> HIV</td> <td><input type="checkbox"/> Mental Health</td> </tr> <tr> <td><input type="checkbox"/> Genetic Testing</td> <td><input type="checkbox"/> Communicable Diseases</td> </tr> </table> <p>Additional Information:</p> <hr/> <hr/> <hr/>	<input type="checkbox"/> Medical	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> HIV	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Genetic Testing	<input type="checkbox"/> Communicable Diseases
<input type="checkbox"/> Medical	<input type="checkbox"/> Substance Abuse					
<input type="checkbox"/> HIV	<input type="checkbox"/> Mental Health					
<input type="checkbox"/> Genetic Testing	<input type="checkbox"/> Communicable Diseases					

Description of Each Purpose for the Use or Release of the Information (Provide a detailed description of the activity for which the information will be used) [45 C.F.R. § 164.508(c)(1)(iv).]
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Will the health plan or provider receive money for the release of this information? [45 C.F.R. § 164.508(a)(3).]
NO, WITH THE EXCEPTION OF COPY COSTS.

STATE OF CALIFORNIA
AUTHORIZATION FOR RELEASE OF INFORMATION
 CDCR 7385 (Rev. 04/06)

DEPARTMENT OF CORRECTIONS AND REHABILITATION

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This authorization for release of the above information to the above-named persons/organizations will expire on: _____ (date). [45 C.F.R. § 164.508(c)(1)(v) & Civ. Code § 56.11(h).]

I understand:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary. [45 C.F.R. § 164.508(c)(2)(i).]
- I have the right to revoke this authorization by sending a notice stopping this authorization to _____ at _____. The authorization will stop on the date my request is received. [45 C.F.R. § 164.508(c)(2)(i) & Civ. Code § 56.11(h).]
- I understand that I am signing this authorization voluntarily and that treatment, payment or eligibility for my benefits will not be affected if I do not sign this authorization. [45 C.F.R. § 164.508(c)(2)(ii).]
- I understand if the organization I have authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. [45 C.F.R. § 164.508(c)(2)(ii).]
- I understand I have the right to receive a copy of this authorization. [Civ. Code § 56.11(i).]

Signature:	CDC/YA Number:	Date:

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

Representative:	Relationship:	CDC/YA Number:	Date: