EXHIBIT J

CENTRAL COAST CENTER FOR INDEPENDENT LIVING
AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

REGARDING RECORDS OF: □ Psychiatric/Medical □ Drug/Alcohol □ Clinical Records Obtained from Other Sources

CONSUMER FULL NAME SOCIAL SECURITY NUMBER

DATE/S OF TREATMENT DATE OF BIRTH

INFORMATION TO BE RELEASED: (CHECK APPROPRIATE BOXES) □ **From** □ **To**

□ **Central Coast Center for Independent Living** **234 Capitol St,** **Suite A** **Salinas, CA 93901** **(831) 757-2968**	□ **Other (Please list)**	□ **Other (Please list)**

INFORMATION TO BE RELEASED: (CHECK APPROPRIATE BOXES) □ **From** □ **To**

Agency Name and Address

TYPE OF INFORMATION TO BE RELEASED: □Discharge Summary □Psychiatric Evaluation □Diagnosis □Intake Assessment □Treatment Plan □Progress Notes □Psychological Testing □Medication Records □Other _____

Purpose and Limitations, if any, for Release: _____

_____

This authorization is effective immediately and is subject to revocation at any time, except to the extent that action has already been taken. This authorization expires one year from the date of signing unless noted. Other expiration date _____.

I am aware of and have been advised of the provisions of existing State and Federal Statutes, Rules and Regulations as outlined on the reverse side of this form, which provide for my right to confidentiality of the information in the records. I am aware of and have been advised of the provisions of The Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996.

I realize that this is a required consent if I wish my records to be released and that I voluntarily and knowingly sign this authorization **BEFORE** any records can be released. I may refuse to sign, but in that event the records cannot and will not be released.

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AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

I understand I have a right to receive a copy of this release. I would like one □ Yes □ No Clients Initials _____

This form has been interpreted for me if not in my chosen language. □ Yes □ No Clients Initials _____

_____ _____
CLIENT WITNESS

_____
IF NOT CLIENT, RELATIONSHIP TO CLIENT DATE

INFORMATION FOR INFORMED CONSENT

The confidentiality of medical, psychiatric and substance abuse information is protected by State and Federal Statutes, Rules and Regulations including but not limited to The Health Insurance Portability and Accountability Act of 1996, California Confidentiality of Medical Information Act; California Administrative Code, Title 22; California Welfare & Institutions Code 5328; Title 42 of the Code of Federal Regulations. These statues, rules and regulations require that the client give informed consent prior to the release of any health/hospital/clinic records or information, except as specifically provided for within these statutes, rules, and regulations.

The client, or authorized representative, must state who the information may be released to, the purpose for which the information may be used, what specific information may be released, and when the authorization will expire. Authorization of the release of information waives any and all right that the client may now have, or may in the future have, to bring any kind of legal action against the County of Monterey, its employees, agents, and servants for any damages caused by the release of the records or other confidential information directly or indirectly related thereto.

Current regulations require that all clients sixteen (16) years and older must consent to the release of information. From twelve (12) to sixteen (16) years it is preferable to obtain the consent of the minor. All minors from twelve (12) to eighteen (18) must also have the written consent of their parent or authorized representative.

All authorized representatives signing with or for the client must submit copies of the legal documents supporting the assignment of this authority. The signature of the authorized representative is required for clients who are conservatees under the Lanterman-Petris-Short Act. (This does not include conservatees under the Probate Code.)

NOTICE OF PROHIBITION OF RE-DISCLOSURE

Federal Rules prohibit the re-disclosure of medical/psychiatric and alcohol or drug abuse information unless further disclosure is expressly permitted by the written consent of the person to who it pertains or as otherwise permitted by Title 42 CFR Part 2. a general authorization for the release of medical or other information **IS NOT** sufficient for this purpose.

The Federal Rules restrict any use of the information obtained to criminally investigate or prosecute any drug or alcohol abuse client.