AMI Housing, Inc.
A California Non-Profit Corporation

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient / Client Identifying Information		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
STREET ADDRESS:	CITY/STATE:	ZIP CODE:
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	CASE NUMBER:

I, the undersigned, hereby authorize and request AMI Housing, Inc. to use or disclose my protected health information, as follows:

- ☐ Placer County Adult System of Care
- ☐ Placer County Children's System of Care
- ☐ Placer County Whole Person Care
- ☐ Whole Person Learning
- ☐ County Social Worker/Case Manager
  (Please Specify): ____________________
- ☐ Other Housing Provider
  (Please Specify): ____________________
- ☐ Other Service Provider
  (Please Specify): ____________________
- ☐ Other *(Please Specify):* ____________
- ☐ Other *(Please Specify):* ____________
- ☐ Turning Point
- ☐ Cornerstone
- ☐ Granite Wellness
- ☐ Golden Sierra Job Training Program
- ☐ Payee Service Provider
  (Please Specify): ____________________
- ☐ Other Housing Provider
  (Please Specify): ____________________
- ☐ County Probation Officer
  (Please Specify): ____________________
- ☐ Other *(Please Specify):* ____________
- ☐ Other *(Please Specify):* ____________

Detailed Description of What Kind of Information To Be Released

- ☐ Entire Record
- ☐ Medical Records Only
- ☐ Mental Health Records Only
- ☐ HIV/AIDS Test Results
- ☐ Social/Medical/Legal History
- ☐ Treatment Attendance / Participation
- ☐ Seclusion Restraint Information
- ☐ Immunization Records Only
- ☐ Diagnosis *(Specify)*: ____________
- ☐ Evaluation/Assessment (e.g. bio-social, psychological, psychiatric)
  (Specify): ____________________
- ☐ Test/Testing Results (e.g. X-rays, EKG, labs, psychological, urinalysis)
  (Specify): ____________________
- ☐ CalWORKs Eligibility & Status

Relevant Dates, if known:

I authorize this release to include information on services I have received for:

☐ Mental Health ☐ Substance Abuse ☐ HIV/AIDS ☐ Genetic Testing

Detailed Description of How Information Will Be Used:
Housing Support Assessment and Service Eligibility. Applicant Monitoring, Progress Tracking/Reporting, Participation, Case Management, Treatment Planning, and all aspects required to manage, assess and provide the same.

This authorization will expire on: _______ (date)

I understand my rights:

- I authorize the disclosure of my health information as described above for the purpose(s) listed. This *authorization* is voluntary, as I understand my health information is subject to Federal and State Privacy regulations.
- I have the right to revoke this *authorization* in writing to the provider of this information listed above. The *authorization* will stop on the date my request is received, except for action(s) taken, or if this *authorization* was obtained as condition of insurance, enrollment, or eligibility.
- I understand the *Notice of Privacy Practices* provides instructions, should I choose to revoke my *authorization.*
- I understand that I am signing this *authorization* voluntarily, as that treatment, payment, or eligibility for my benefits will not be affected if I do not sign this *authorization* unless my treatment, enrollment in a health plan, or eligibility for benefits are conditioned on me signing the *authorization.*
- 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.
- I understand I have a right to receive a copy of this authorization.

Signature of Patient/Client:	Date:

Photocopy of thus *authorization* shall have the same meaning as the original.

Signature of Parent, Guardian, Conservator, or Legal Representative (indicate relationship):	Date: