AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION
Independent Adoption Program

I, _____ born _____, hereby authorize
Birth/Legal Parent's Name or Legal Guardian — Date of Birth

_____ to disclose information regarding
Physician, Hospital, Clinic, School, Therapist or Agency

☐ My medical history, mental or physical condition, care, or treatment

☐ The medical history, mental or physical condition, care, or treatment of my child, _____
Child's Name

born _____.
Date of Birth(s)

My relationship to this child is _____

The information is to be released to the:

☐ California Department of Social Services

☐ Delegated County Adoption Agency
Address: _____

City, State, Zip Code: _____

Telephone Number: ( ) _____

☐ Other _____

- Parent/Legal Guardian must complete one form for each person/agency

PATIENT'S AUTHORIZATION TO RELEASE INFORMATION
Restrictions/Duration/Rights

My authorization limits the disclosure of this information to the agency listed on page one for the purposes of adoption planning. This authorization is for any information in your files concerning me and if applicable, the child named on page one, including the following types of information:

- ☐ Medical Information and History
- ☐ Psycho-Social Information and History
- ☐ Test or Examination Results
- ☐ Other Information and/or Explanation: _____

_____

- I authorize the release of the specified information from my/the child's medical records.
- I understand information disclosed pursuant to this authorization, may be re-disclosed by the recipient and no longer protected by federal confidentiality laws. However, use and redisclosure of the information are subject to the requirements of Family Code Section 9200 et seq. and Title 22 California Code of Regulations Sections 35049 et seq. and 35051 et seq.
- This authorization may be revoked at any time. My revocation will be effective upon receipt but will have no impact on uses or disclosures made while my authorization was valid.
- This authorization will become effective immediately and will expire one year from the date of signature.
- A photocopy of this release is as effective as the original.
- I understand that I have a right to receive a copy of this authorization.

SIGNATURE:	DATE:

This document complies with the privacy requirements of the Health Insurance Portability and Accountability Act.