AUTHORIZATION FOR RELEASE, USE AND/OR DISCLOSURE OF HEALTH INFORMATION
AGENCY ADOPTION PROGRAM

I,_____, (first, middle, last name)

_____ (position/role), the authorized agent of the child named

_____ (child's legal name on birth certificate),

born on _____, hereby authorize the "Person/Organization Providing the Information" listed below to disclose the above-named child's medical history, mental or physical condition, care, or treatment information to the "Person/Organization Receiving the Information" listed below.

Person/Organization Providing the Information	**Person/Organization Receiving the Information** ☐ **California Department of Social Services** ☐ **County Adoption Agency** ☐ **Licensed Adoption Agency**
Name:	Name:
Organization Name:	Organization Name:
Position or Role:	Position or Role:
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone # :	Phone # :
Fax #:	Fax #:

PURPOSE AND LIMITATIONS FOR THE RELEASE, USE, AND/OR DISCLOSURE OF INFORMATION

My authorization limits the disclosure of the child's information to the above "Person/Organization Receiving the Information" for the purposes of adoption planning. The information will not be used for any purpose other than its intended use. This authorization is limited to the items checked off under "Information to be Released" below.

Information to be Released

Medical Information and Health History
Test or Examination Results
Mental/Behavioral Health Records
Other Information and/or Explanation:

Psycho-Social Information and History
Labor & Delivery

For the following period of time: From _____(date) To _____ (date)

I understand that:

- I authorize the release, use, and/or disclosure of the child's individually identifiable health information as described above for the purpose of adoption planning.
- If the organization or person 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.
- This authorization is voluntary.
- I have the right to revoke this authorization at any time by sending a signed notice stopping this authorization to _____ (Person/Organization Providing the Information) at _____. (address) The authorization will cease on the date my valid revocation request is received but will have no impact on uses or disclosures made while my authorization was valid. Please also see the Notice of Privacy Practices provided by "Person/Organization Providing the Information."
- My treatment, payment, enrollment, or eligibility for any benefit, program or service will not be affected if I do not sign this authorization.
- Under California law, the recipient of the information released, used or disclosed pursuant to this authorization is prohibited from re-disclosing the information, except with a written authorization or as specifically required or permitted by law. For example, use and disclosure of the information are subject to the requirements of Family Code section 9200, et seq., and Title 22, California Code of Regulation section 35049, et seq.
- This authorization shall become effective immediately and will expire on _____ (date), one year from the date of signature.
- A photocopy of this authorization is as effective as the original.
- I have a right to receive a copy of this authorization.

- Medical information obtained relating to outpatient psychotherapy care shall be maintained in the adoption record and shall be kept indefinitely.

Authorized Agent's Basis for Signature:

The above-named child is a dependent of the _____ County Juvenile Court, is in the placement and care responsibility of _____ (child welfare agency), and I am an employee of that agency.
The above-named child is in the custody of _____ Adoption Agency for the purposes of adoption planning and I am an employee of that agency.

SIGNATURE OF CHILD'S AUTHORIZED AGENCY	Date

This document complies with the Health Insurance Portability and Accountability Act of 1966 (HIPAA, P.L. No. 104-191, 110 Stat. 1938 (1996)), the HIPAA regulations (45 CFR Parts 160, 162, and 164), and the California Confidentiality of Medical Information Act (CMIA, California Civil Code section 56, et seq.)