A photocopy/facsimile copy may be used as an original.

CLIENT INFORMATION		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS	CITY/STATE/ZIP CODE:	DATE OF BIRTH:
CLIENT'S PHONE NUMBER	CLIENT FILE/CASE NUMBER	

AUTHORIZATION DETAILS

Medical Records Coming From **(Disclosed by):** Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to make use of and/or disclose the PHI described in this form.

_____ _____

_____ _____

_____ _____

Medical Records Going To **(Received by):** Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to receive the PHI described in this form.

_____ _____

_____ _____

_____ _____

PURPOSE OF DISCLOSURE OF PHI

☐ At the request of the individual/client ☐ At the request of an authorized representative

SERVICE DATES

The information to be used or disclosed includes only those items checked above, with respect to services provided on or around: _____ (insert dates of service). **NOTE:** If this section is left blank, the treatment dates covered by this authorization are from the most recent preadmission to discharge and claims resolution.)

EXPIRATION OF AUTHORIZATION

THIS AUTHORIZATION SHALL BECOME VALID IMMEDIATELY AND SHALL REMAIN IN EFFECT FOR THE FOLLOWING PERIOD: ***(The Client/Patient MUST INITIAL one of the following for the authorization to become valid.)***

_____ This authorization expires one year from the signature date below.

_____ This authorization expires as specified: _____

_____ This authorization expires once PHI is disclosed. This is a one-time authorization.

TYPE OF PHI TO BE USED OR DISCLOSED

I understand that this authorization extends to all or any part of the records/information designated below, which may include treatment for mental illness and/or alcohol/drug abuse. The information to be used or disclosed includes: *(The client MUST INITIAL items being requested)*

(_____) Discharge Summary (_____) Alcohol/Drug Records
(_____) Psychiatric Evaluation/MSE (_____) Attendance Only
(_____) Medication Records (_____) Lab Reports
(_____) Inpatient Records (_____) Intake/Admission Summary (_____) Medical Finding
(_____) Progress Notes: SPECIFY _____
(_____) OTHER (please specify): _____

This authorization is limited to only that information that I have requested above to be used or disclosed to the persons/facilities named herein. I hereby release the County of Butte from all legal responsibilities or liability that may arise from the use or disclosure of health information in reliance on this authorization.

NOTICE TO RECIPIENT OF PHI

Please note Federal Confidentiality Rules (42 CFR Part 2) and California Law prohibit further disclosure of medical and/or mental health records, unless further use or disclosure is expressly permitted by obtaining a written authorization for disclosure of information from the person to whom it pertains. A general authorization for the use or disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

CLIENT RIGHTS & RESPONSIBILITIES

1. **Re-Disclosure under HIPAA:** I understand that information used or disclosed in accordance with this authorization may no longer be protected by the Health Insurance Portability & Accountability Act of 1996 (HIPAA), and could be used or re-disclosed by the receiving party. However, as noted below, federal and state regulations governing the confidentiality of alcohol and drug abuse patient records will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from re-disclosure.
2. **Revocation:** I have the right to make a written request to stop the use or disclosure of information at any time although I understand that I cannot do anything about information already used or disclosed under this authorization.
3. **Refusal to sign:** I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits except as may be permitted by law.
4. **Copy:** I understand that I will receive a copy of this authorization upon my request. However, for requests for other file copies, a fee may apply.
5. **Minors:** I understand that minors 12 years of age and older may be required to sign the authorization along with their parent/guardian.

Butte County Department of Behavioral Health Authorization for Use or Disclosure of Protected Health Information (PHI)	**Client Name:** _____ **Client Number:** _____

ACKNOWLEDGEMENT

Client Signature: _____ Today's Date: _____

If Applicable:

Parent/Guardian/Authorized Representative Signature: _____
Today's Date: _____
Print Name: _____ Telephone Number: _____
Complete Address: _____
Street Address *City* *State* *Zip Code*
Relationship to Client _____

REVOCATION OF AUTHORIZATION

As of this date, _____) I hereby revoke this authorization.

_____ _____
Name of Client Signature of Client Revoking Authorization

If Appficable:

_____ _____
Name of Parent/Guardian Signature of Parent/Guardian Revoking Authorization

STAFF VERIFICATION

(FOR INTERNAL USE ONLY)

☐ I have verified the client's signature against the medical record.
☐ I have received _____ as documentation that verifies the relationship with the client and the authority to request/receive health information on behalf of the client.

Staff Signature: _____ Date: _____

Print Staff Name: _____

* *

COPY: ( ) DELIVERED ON _____ ( ) FAXED ON _____ ( ) MAILED ON _____
( ) RETAINED IN FILE ONLY ( ) GIVEN TO CLIENT ON _____

Butte County Department of Behavioral Health Authorization for Use or Disclosure of Protected Health Information (PHI)	Client Name: _____ Client Number: _____

CLIENT INFORMATION

Provide all information as requested. The bottom right box is to be used for an additional identifier (e.g. SS#) ***only*** *when all other information cannot distinguish one client from another.*

AUTHORIZATION DETAILS

Medical Records Coming From (Disclosed by): *Enter the complete name and address of the person and/or organization that has the information.*

Medical Records Going To (Received by): *Enter the complete name and address of the person and/or organization to which the information is to be sent.*

PURPOSE OF DISCLOSURE OF PHI

Check the box that applies.

SERVICE DATES

Enter the dates during which services or other information occurred.

EXPIRATION OF AUTHORIZATION

Initial next to the applicable term of the authorization.

NOTICE TO RECIPIENT OF PHI

This notice lets whoever your information is sent to know that they cannot release it to anyone else without your permission.

TYPE OF PHI TO BE USED OR DISCLOSED

Initial next to all applicable items.

CLIENT RIGHTS & RESPONSIBILITIES

These notices describe your rights and responsibilities related to this authorization.

ACKNOWLEDGEMENT

Client Signature: ____ Today's Date: ____________________

Sign your name here and write in the date.

Parent/Guardian Signature: ______________________________________ Today's Date: ____________________

Print Name: ____ Telephone Number: ____________________

Complete Address: ____

Street Address *City* *State* *Zip Code*

This is filled in by the person completing the form if they are not the client.

REVOCATION OF AUTHORIZATION

Complete this section if you decide you don't want your information to be released any longer.

STAFF VERIFICATION

(FOR INTERNAL USE ONLY)

This section is completed by staff when they have verified that you are authorized to make this request.

* *

COPY: ( ) DELIVERED ON ________________ ( ) FAXED ON ____________________ ( ) MAILED ON ________________

( ) RETAINED IN FILE ONLY

If you requested a copy of this form, staff marks how it was given to you. If you did not request a copy of this form, staff marks that it is in your file.

ICMA RETIREMENT CORPORATION
The Public Sector Expert

How your 457 plan works

How do I start?

Return completed enrollment form to your personnel department. If you have any questions regarding your investment options or how to complete the enrollment form, please call me at **866-749-5180.**

How much can I defer?

The maximum contribution for 2006 is $15,000 or 100% of taxable compensation. If you are 50 or older, you may contribute an additional $5,000, for a total of $20,000. You may start with as little as $10 per pay period.

How do I transfer assets from other retirement plans.

You can transfer assets from previous employer's 457 plan or consolidate retirement assets from a 401(k), IRA, or 403 (B) into your 457 account. Call me for further information on this option.

How do I monitor my account?

You can logon to our website at www.icmarc.org**,** and request an Internet password. You may call our Vantageline at 1-800-669-7400 to establish you four-digit pin number for the telephone. In addition, You will also receive quarterly statements from us.

When can I withdraw my funds?

There is no age specific penalty for withdrawing money from your 457 Plan. It is available upon separation from service.

CALL ME FOR A PERSONAL CONSULTATION AND PROJECTION!

As a not-for-profit organization created by the public sector, for the public sector, it is my pleasure to assist you with your retirement goals. I look forward to speaking with you and thank you for your interest. I well be at the **Butte County Human Resources Dept. Monday March 20th (9am to 4pm.) For a personal consultation, Call @ (866) 749-5180**

Mark Tomasini, Retirement Plans Specialist
866-749-5180
mtomasini@icmarc.org