AUTHORIZATION TO RELEASE INFORMATION

By signing this form, I *(print your name)* _____ authorize the release of the following personal health information *(check all that apply)*:

- ☐ Mental health history, diagnosis, and treatment (includes psychiatric medications).
- ☐ Medical health history, diagnosis, and treatment.
- ☐ Substance use history, diagnosis, and treatment.
- ☐ Other:
- ☐ With the following limitations to disclosure:

This information is to be shared between

Bay Area Trauma Recovery Clinical Services (BATRCS)
3220 A. Sacramento Street
Berkeley, CA 94702
(510) 660-1493

and the following person(s) or agencies/facilities:

Agency Name:
Phone or Fax:
Address:

This authorization shall remain valid for 1 year since signature or until:

I understand that I can refuse to sign this authorization and that BATRCS may only condition treatment upon my signing of this form if the release of information is considered critical to the provision of appropriate care, including to ensure my safety. I also understand that I have a right to receive a copy of this authorization.

I understand that I have the right to modify, cancel, or revoke this authorization at any time, unless BATRCS has already taken action in reliance upon it. I agree that all such requests must be made in writing and submitted to BATRCS.

I understand that BATRCS and many other organizations & individuals, such as physicians, hospitals, and health insurances are required by law to keep my health information confidential. However, if I authorize the disclosure of my health information to someone who is not legally required to keep it confidential, state or federal confidentiality laws may no longer protect it.

Client Signature: Date:

Witness Signature: Date: