CONFIDENTIAL

SUPERIOR COURT OF CALIFORNIA, COUNTY OF SAN DIEGO ☐ CENTRAL DIVISION, CENTRAL COURTHOUSE, 1100 UNION ST., SAN DIEGO, CA 92101 ☐ EAST COUNTY DIVISION, 250 E. MAIN ST., EL CAJON, CA 92020 ☐ NORTH COUNTY DIVISION, 325 S. MELROSE DR., VISTA, CA 92081 ☐ SOUTH COUNTY DIVISION, 500 3RD AVE., CHULA VISTA, CA 91910	*FOR COURT USE ONLY*
PLAINTIFF PEOPLE OF THE STATE OF CALIFORNIA	
DEFENDANT	SUPERIOR COURT CASE NUMBER
AUTHORIZATION FOR RELEASE & EXCHANGE OF CONFIDENTIAL HEALTH INFORMATION (HIPAA) – COLLABORATIVE COURT PROGRAMS (CONFIDENTIAL)	OTHER IDENTIFYING NUMBER(S)

Authorization for Release and Exchange of Confidential Health Information (HIPAA)

I, _____, hereby authorize the release and exchange of confidential health information among the _____ (*collaborative court*) team members, including, but not limited to the following: _____ (*treatment provider*), San Diego Sheriff's Department, San Diego Public Defender's Office, San Diego District Attorney's Office, San Diego City Attorney's Office, San Diego Superior Court, San Diego Police Department or other local police agency, San Diego Probation Department, and Judicial Council of California. The purpose and need for this release is to assist in evaluating and determining appropriate treatment, progress, and compliance with the collaborative court program.

Information/Records to be Released

- ☒ Mental Health Evaluation
- ☒ Medication Records
- ☒ Psychiatric Assessment
- ☒ Client/Service Plan
- ☒ Physician Orders
- ☒ Diagnosis
- ☒ Billing Records
- ☒ Nursing Notes
- ☒ History & Physical Exam
- ☒ Laboratory Results
- ☒ HIV/AIDS Information/Results
- ☒ Progress Notes
- ☒ Pharmacy Records
- ☒ Psychological Evaluation
- ☒ Alcohol/Drug Treatment Records
- ☐ Other: _____

I understand that the information in my records authorized for release may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). As indicated above, it may also include information about mental health services or treatment for substance abuse.

I understand that my alcohol and drug treatment records and my confidential health information are protected by the Federal Regulations governing Substance Abuse Patient Records (42 C.F.R., § 2.1 et seq.) and the Health Insurance Portability and Accountability Act ("HIPAA") (45 C.F.R., §§ 160.101 et seq. and 164.102 et seq.) and cannot be released without my specific written authorization, unless the disclosure is otherwise provided for in the above-referenced regulations, including, by judicial order.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in the Code of Federal Regulations (45 C.F.R., § 164.524).
I understand that I have the right to revoke this authorization at any time. If I choose to revoke this authorization, I must do so in writing. Revocation will not apply to information that has already been released based on this authorization.

I understand that, to the extent the treatment provider above is providing health care solely for the purpose of creating protected health information for disclosure to a third party, including the collaborative court team members above, the treatment provider may condition the provision of such health care on my execution of this authorization.

I understand that information disclosed pursuant to this authorization may no longer be protected and potentially be subject to re-disclosure by the recipient.

I agree that a photocopy or fax of this authorization for release and exchange of confidential health information will be as effective as the original.

This authorization will go into effect on the date of signing and will remain in effect until the collaborative court program is terminated or completed or until this authorization is revoked, whichever occurs earlier.

I request a copy of this authorization. (Initial here for copy): _____
Copy given: ☐ YES ☐ NO

Date: _____ Date of Birth:_____
Social Security Number:_____

_____ _____
Type or print name Signature of Participant