ALCOHOL, DRUG & MENTAL HEALTH SERVICES
MANUEL JIMENEZ, MA, MFT, DIRECTOR

Quality Assurance Office
Consumer Assistance
2000 Embarcadero Cove, Suite 400
Oakland, California 94606
(510) 567-8100 / TTY (510) 567-6884
Toll Free: 1 (800) 779-0787
FAX: (510) 639-1346

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

(Please fill out both sides of this form)

____ ______________
Consumer's Last Name First Name Middle Name Date of Birth

____ ______________
Street Address City Zip Code Daytime Telephone

____

I, the undersigned, hereby authorize the release of my confidential information, including medical and psychiatric records, from:

____ ______________
Health Care Provider Name Telephone

____ ______________
Street Address City/State Zip Code FAX # (if known)

to: ACBHCS – QA Office
Consumer Assistance
2000 Embarcadero Cove, Suite 400
Oakland, CA 94606

for the purpose of resolving my grievance or appeal request. I further authorize you to provide such copies thereof as may be requested.

This authorization is subject to the following limitations (check one):

☐ All medical records

☐ Confined to records regarding treatment from the period from _______ to ______

☐ Confined to records regarding admission and treatment for the following medical

condition or injury:____

☐ Confined to the following specified information: ______________________________

____

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall

terminate six (6) months from the date of consent. The signer may revoke this release in writing or by verbally informing Consumer Assistance.

____ ____________

Signature of Consumer, Legal Guardian, Representative (Circle one) Date

____ ____________

Signature of Witness Date

Any disclosure of medical records information by the recipient(s) is prohibited except when implicit in the purpose of the disclosure.