

## AUTHORIZATION FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION Agency Adoption Program

I, \_\_\_\_\_, the authorized agent of \_\_\_\_\_  
AGENT'S NAME CHILD'S NAME

born \_\_\_\_\_, hereby authorize \_\_\_\_\_ to disclose  
DATE OF BIRTH PHYSICIAN, HOSPITAL, CLINIC, SCHOOL, THERAPIST OR AGENCY

information regarding the above-name child's medical history, mental or physical condition, care, or treatment to the following:

- California Department of Social Services (CDSS)
- \_\_\_\_\_ Licensed Adoption Agency

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Telephone Number: (    ) \_\_\_\_\_

### AGENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION Restrictions/Duration/Rights

My authorization limits the disclosure of the child's information to the above agency for the purposes of adoption planning. This authorization is limited to the following types of medical information:

- Medical Information and History  Psycho-Social Information and History
- Test or Examination Results  Labor & Delivery
- Other Information and/or Explanation: \_\_\_\_\_

- I authorize the release of the specified information from the child's medical records.
- I understand information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal confidentiality laws. However, use and redisclosure of the information are subject to the requirements of Family Code Section 9200 et seq. and Title 22 California Code of Regulations Section 35127.1 et seq. and Section 35049 et seq.
- This authorization may be revoked at any time. My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- This authorization will become effective immediately and will expire one year from the date of signature.
- A photocopy of this release is as effective as the original.
- I understand that I have a right to receive a copy of this authorization.

- The above-name child is a dependent of the \_\_\_\_\_ County Juvenile court.
- The above-name child is in the custody of \_\_\_\_\_ Adoption Agency for the purposes of Adoption Planning.

SIGNATURE OF AUTHORIZED AGENCY: \_\_\_\_\_

DATE: \_\_\_\_\_

This document complies with the privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA)