



FIRST 5 ALAMEDA COUNTY AUTHORIZATION TO RELEASE AND EXCHANGE INFORMATION

I, _____
Parent/Guardian First Name Parent/Guardian Last Name Date of Birth

and my child: _____
Child First Name Child Last Name Date of Birth

authorize the following agency/ies and their representatives working with First 5 Alameda County to release and exchange information and/or records about myself and/or child listed above to plan and provide services for my family:

Name of Person and Agency Phone

Street Number Street Name Unit Number City Zip

AND

Name of Person and Agency Phone

Street Number Street Name Unit Number City Zip

THE FOLLOWING INFORMATION IS AUTHORIZED TO BE RELEASED AND EXCHANGED:

All health information pertaining to my medical history, physical condition and treatment received

Only the following records or types of health information:

I SPECIFICALLY AUTHORIZE THE RELEASE OF THE FOLLOWING INFORMATION (CHECK AS APPROPRIATE):

- Mental Health treatment information (as noted in medical file or by my report)
- All HIV test results
- Alcohol-drug treatment information

I UNDERSTAND THAT:

- **This authorization is voluntary.** If I choose not to sign it, I will still receive services as outlined in First 5 Alameda County’s Authorization for Services.
- I may review or obtain a copy of the health information that will be released or exchanged by writing to: First 5 Alameda County, 1115 Atlantic Avenue, Alameda, CA 94501.
- First 5 Alameda County will release or exchange information to providers necessary for providing services to my family as outlined in this authorization. Information shared under this authorization could possibly be shared by the agency/provider. First 5 Alameda County cannot control what the agency/provider does with this information. In some cases, California law prohibits the agency/provider receiving my health information from making further disclosures of it unless another authorization for that disclosure is obtained from me or unless that disclosure is specifically required or permitted by law. However, it is the agency’s/provider’s responsibility to determine what its legal and other obligations are with this information and for them to comply with those obligations.
- I have received a copy of this form and can request an additional copy of this form by writing to: First 5 Alameda County, 1115 Atlantic Avenue, Alameda, CA 94501.
- I may cancel this authorization at any time by writing to: First 5 Alameda County 1115 Atlantic Avenue, Alameda, CA 94501. The cancellation will take place when First 5 Alameda County receives the request. First 5 Alameda County I unable to take back any disclosures already made with my authorization, and are required by law to retain records of the care provided to me.
- It is very important to First 5 Alameda County that my private information is confidential. Strict data protection standards and up-to-date technology will be used to safeguard and protect my information.

This Authorization automatically expires on _____ (or 1 year from date of signature).

Print Name: _____ Relationship to Child: _____

Signature: _____ Date: _____

Witness: _____ Title/Relationship: _____

The Amendment to Children & Families Act protects any individually identifiable information collected by First 5 California Commissions from disclosure to unauthorized entities unless consent was obtained from the client, parent or legal guardian.