SAN DIEGO COUNTY SHERIFF'S DEPARTMENT

Medical Services Division

Authorization for Use and Disclosure of Protected Health Information
(Release of Information Request)

I authorize (releasing party):		**To disclose to (receiving party):**	
Name	San Diego County Sheriff's Department Medical Services Division	**Name**	
Address	5530 Overland Ave. Ste. 370	**Address**	
City/State	San Diego CA, 92123	**City/State**	
Phone	(858) 974-5848	**Phone**	
Fax	(858) 974-5854	**Fax**	

This disclosure may be used for the following purpose(s):
☐ Continuity of Healthcare ☐ Personal Use ☐ Public Benefit Program/Disability Claim
☐ Legal ☐ Other specific uses or limitations:

Indicate one of the following:
☐ **Date(s) of service requested**: ____________________
☐ **or Booking number(s) requested**:

I authorize the use and disclosure of my protected health information (PHI) for health care received for any illnesses, conditions, and injuries for the date(s) of service or booking number(s) indicated above; **OR** release only the following specific medical records for the date(s) of service or booking number(s) indicated above: ____________________
____________________.

I further understand sensitive PHI such as mental health records, alcohol/drug abuse records, and HIV test results will not be included in this authorization for release of information request unless the sensitive information is specifically indicated below.

Please check the boxes of the sensitive information you authorize with this release of information request:

☐ **ALCOHOL/SUBSTANCE ABUSE** ☐ **HIV** test results
☐ **MENTAL HEALTH RECORDS** ☐ Other:

Note: a separate written authorization is required for each disclosure of HIV test results.

Duration: This authorization will expire in twelve (12) months or on this date:

Medical Records Format: ☐ Paper (default) ☐ Electronic (CD)

COPY OF ROI: I understand I am entitled to a copy of this Release of Information Request and a completed copy of this form is as valid as the original.
REDISCLOSURE: California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained or unless such disclosure is specifically required or permitted by law.

Patient's Name: ____________________
D.O.B.: ____________________
Booking#: ____________________
Date: (mm-dd-yy) ____________________

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REVOCATION: I understand I may revoke this authorization at any time by notifying San Diego County Sheriff's Department, Medical Services Division in writing.

NOTICES:

- I understand that the San Diego County Sheriff's Department may not condition treatment on whether I sign this authorization.
- Medical records released pursuant to this written authorization may contain references related to mental health, alcohol/substance abuse, and HIV.
- This authorization will be invalid if: not signed by the patient or patient's personal representative; the expiration date has passed; the form is incomplete; or if the authorization form has been revoked in writing by patient or patient's personal representative.
- If medical records are required for continuity of care with your provider upon release, indicate them as the receiving party and they shall receive the medical records specified by the signed Release of Information Request form at no cost.
- Requests for mental health records may be denied. However, the mental health records may be provided to other providers as designated by your release of information request at no cost.
- A completed and signed Release of Information Request form may be mailed or faxed to:

San Diego County Sheriff's Department
Attn: Medical Services Division
5530 Overland Ave. Ste. 370
San Diego, CA 92123
Phone: 858-974-5848
Fax: 858-974-5854

- Fees may apply to certain medical record requests. A fee of twenty cents ($0.20) per page will be charged for paper records requested for personal use (or $5 for copies on CD). If fees apply, an invoice will be sent to you. Please arrange to have a cashier's check or money order sent to the address above and made payable to the San Diego County Sheriff's Department. The medical records requested will be sent to the authorized party once payment is received.

_______________	_______________	_______________		
Patient's Name	AKA			JIMS Number
Patient's Signature (or Other Authorized Representative)	Date	Social Security Number	Date of Birth	CDCR Number (if available)

If not signed by patient, specify basis for authority to sign:

- ☐ Attorney-In-Fact for Health Care (attach copy to this authorization)
- ☐ Conservator, Beneficiary, or Personal Representative (attach copy of legal document)
- ☐ Other (attach copy of document)

Patient's Name: ____________________
D.O.B.: ____________________
Booking#: ____________________
Date: (mm-dd-yy) ____________________