Riverside University Health System – Behavioral Health
Assessment and Consultation Team (ACT)
Authorization Requesting Release/Receipt of Information and/or Records

(Confidential Patient Information – W & I Code Sec. 5328)

Patient's Name: _____ **Date of Birth:** _____

The Department of Public Social Services has arranged and is partially funding treatment services for you as a part of a service plan through the Juvenile Court. As a part of this process, there is a need to share information between your clinician/provider, Riverside University Health System – Behavioral Health and the Riverside County Department of Public Social Services. This release of information allows for this exchange of information. If you do not wish to sign this authorization, you may still receive confidential services through your own resources. If desired, discuss possible treatment resources with your clinician and, if you wish, with your DPSS social worker.

I, the undersigned, hereby authorize the following to release and exchange information. Please be advised that this authorization allows disclosure as described above and Riverside University Health System – Behavioral Health cannot be held liable for how this information is used by the person/agency to whom the disclosure is made to and their safeguard practices.

Provider: _____ Phone Number: _____

Riverside University Health System – Behavioral Health Assessment & Consultation Team
Riverside County Department of Public Social Services

Information may be released with the knowledge that such contact discloses the fact that mental health and/or chemical dependency services have been/are being provided.

This disclosure may include any of the following:
Assessment & Diagnosis
Consumer Care Plan and Discharge Summary
Psychological Testing
Medical, Neurological, Lab Tests, Medications
Progress Reports

This authorization becomes effective _____/_____/_____. This authorization may be revoked by the undersigned at any time, except to the extent that information has already been released. If not revoked, it shall terminate one year from the date of authorization. You have the right to have a copy of this Authorization upon request.

Date: _____ Consumer Signature: _____

☐ Authorization Revoked: _____/_____/_____ Consumer Signature: _____

☐ I refuse all release of information.

Date: _____ Consumer Signature: _____