Authorization to Disclose Protected Health Information

General Information Regarding This Authorization:

This Authorization permits Catalight Care Services, Easterseals Hawaii (ESH) and Easterseals Northern California (ESNorCal) (referred to as "Company" from here on) to disclose the Protected Health Information ("PHI") of the specified client. This Authorization form must be filled out completely for the Company to disclose the requested information.

Request for Disclosure of Information Containing PHI regarding:

Client First Name | Client Middle Name | Client Last Name

Date of Birth | Medical Record Number (MRN)/Unique Client Identifier (UCI)

Person/Organization Is Authorized To Disclose my Information:

Name: Catalight Care Services / Easterseals Hawaii / Easterseals Northern California
Address: 2730 Shadelands Drive, Walnut Creek, CA 94598
Phone: (855) 843-2476

Purpose of disclosure:

☐ Personal ☐ School ☐ Insurance ☐ Other _____

Disclose record to: ☐ Myself(address below) ☐ Third-party (address below)

To Person/Organization:

First Name | Last Name

Street | City | State | Zip Code

Phone ( ) | Email

Records to be sent via: ☐ Mail/USPS ☐ Encrypted Email ☐ Pick up at Company

Description of the Information to be Disclosed:

☐ BHT Initial Assessment Report ☐ Assessment Report ☐ Progress Report
☐ Clinical Case Management Notes ☐ Transition Report ☐ Discharge Report
☐ Other _____

Covering record period from: Beginning _____ Ending _____

Release Record for:

☐ One time release ☐ _____ months (cannot exceed 12 months)

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Rights Related to Authorization

The Client or Person legally authorized to sign this form has the following rights regarding the authorization:

- The right to revoke this Authorization in writing at any time by submitting written notice to the Company at the address at the bottom of the form. The Company has the right to rely on this Authorization until such time I revoke it.
- This Authorization is effective up to one year from its effective date unless a lesser time frame is stated in the “Release of Record for” or it is revoked prior to the expiration date.
- The right to refuse to sign this Authorization. treatment, payment, enrollment or eligibility for benefits will not be determined or dependent on my providing or refusing to provide this authorization.
- The right to receive a copy of this Authorization, as well as the right to inspect or copy the health information disclosed by this Authorization.

I understand that information disclosed as a result of this Authorization could be re-disclosed by the recipient. Such re-disclosure is, in some cases, not protected by California law and may no longer be protected by federal confidentiality law.

I release all persons complying with this authorization, including the Company employees and agents, from any liability arising from the disclosure of this information to the above-designated person or agency.

By signing this Authorization, I certify that I have the legal authority to do so.

Legally Authorized Decision Maker Name: _____

Signature: _____

Date: _____

Relationship to Client: _____

Mail or email the completed form to:

Quality Department
2730 Shadelands Drive
Walnut Creek, CA 94598

ClientRecords@catalight.org