

All sections must be completed for the authorization to be honored. Use "N/A" if not applicable.

I. Patient Information

Last Name: _____ First Name: _____ Middle Name: _____
CDCR# _____ Date of Birth: _____
Street Address: _____ City/State/Zip: _____

II. Individual/Organization Authorized to Release Personal Health Records if Other Than CDCR

Name: _____
Address: _____ City/State/Zip: _____

III. Individual/Organization to Receive the Information

[45 C.F.R. § 164.508(c)(1)(ii), (iii) & Civ. Code § 56.11(e), (f)]

The undersigned hereby authorizes CDCR's Health Information Management to release the health information pursuant to this authorization.

Name: _____
Relationship to Patient: _____ Phone: _____ Fax: _____
Address: _____ City/State/Zip: _____

**IV. Authorization Expiration Event or Expiration Date for Release of Verbal Information/
Written Correspondence**

[45 C.F.R. § 164.508(c)(1)(v) & Civ. Code § 56.11(h)]

Unless otherwise revoked by the patient, this authorization for the release of health care information to the above-named individual/organization will expire on the date specified below, event identified, or 12 months from the date signed in Section IX, whichever occurs first:

Date of Expiration: _____ Event: _____
From (mm/dd/yyyy): _____ To (mm/dd/yyyy): _____

V. Health Care Records to be Released - General

[45 C.F.R. § 164.508(c)(1)(i) & Civ. Code § 56.11(d), (g)]

I authorize records for the following period of time to be released (must be completed to receive records):

From (mm/dd/yyyy): _____ To (mm/dd/yyyy): _____

☐ Medical Services ☐ Dental Services ☐ Other: _____

NOTE: Health records released as part of this authorization may contain references related to mental health, substance use disorder, medication assisted treatment, genetic testing, communicable disease, and HIV medical conditions.

VI. Health Records to be Released - Specify

[45 C.F.R. § 164.508(c)(1)(i) & Civ. Code § 56.11(d), (g)]

☐ Communicable Disease Records	from _____ to _____	Signature: _____	Date: _____
☐ Genetic Testing Records	from _____ to _____	Signature: _____	Date: _____
☐ HIV Test Results	from _____ to _____	Signature: _____	Date: _____
☐ Medication Assisted Treatment Records	from _____ to _____	Signature: _____	Date: _____
☐ Mental Health Treatment Records	from _____ to _____	Signature: _____	Date: _____
☐ Substance Use Disorder Records	from _____ to _____	Signature: _____	Date: _____

NOTE: Health records released as part of this authorization may contain references related to dental, medical, mental health, substance use disorder, medication assisted treatment, genetic testing, communicable disease, and HIV conditions.

Requests for psychotherapy notes require a separate CDCR 7385 and may not be combined with any other request for health records.

☐ Psychotherapy Notes