**Appendix E**

**The Navigator Project**

San Francisco Pretrial Diversion Project, Inc.

567 7th St.

San Francisco, CA 94103

(415) 626-4995

(415) 626-3871 (FAX)

**AUTHORIZATION TO RELEASE/REQUEST CONFIDENTIAL PATIENT INFORMATION**

 I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to disclose/obtain records acquired in the course of my diagnosis and treatment to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_for the following:

**\_\_\_Medical-** any such disclosure shall be limited to the following specific types of information or dates of treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**\_\_\_Psychiatric-**any such disclosure shall be limited to the following specific types of information or dates of treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I understand that psychiatric records are protected by the California Welfare and Institutions Code section 5000 et. seq. and are not subject to re-disclosure.

**\_\_\_HIV-**any such disclosure shall be limited to the following specific types of information or dates of treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I understand that if my medical records contain results of any HIV blood test or other information about AIDS/ARC/HIV, this information will be disclosed as part of the medical record to the person authorized below to receive records.  By initialing this box, I am providing written authorization, as defined in Health and Safety Code section 199.21 G to disclosure of that information.

**\_\_\_Alcohol and/or Drug Use-**any such disclosure shall be limited to the following specific types of information or dates of treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I understand that if my medical records contain alcohol and/or drug related information, this information is protected by federal laws and regulations and is not subject to re-disclosure.

This authorization shall become effective immediately and shall remain in effect for this one request only unless otherwise specified.  This authorization will terminate on

\_\_\_\_\_\_\_\_\_\_\_\_

Date

I understand that I have a right to a copy of this authorization upon my request.

\_\_\_\_\_\_\_\_\_\_\_\_                            \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date                                                 Signature of Client/Agent

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client's Printed Name and Date of Birth

Witness' Signature