Central Coast Behavioral Health Inc.
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HIPPA RELEASE FORM FOR CRISIS STABILIZATION

I, ___________________________ **(Patient Name)**, ______________ **(DOB)** herby authorize Central Coast Behavioral Health, Inc. for purpose of the following **(Please Check One):**

____ Release/Obtain/Discuss information with the following individuals, if Central Coast Behavioral Health believes that **I am a danger to myself or others**.

Name: _____________________ Relationship: _________ Telephone Number: _______________

Name: _____________________ Relationship: _________ Telephone Number: _______________

Name: _____________________ Relationship: _________ Telephone Number: _______________

The following information:

Information pertaining to my immediate safety and wellness, including: all information, outpatient records, psychiatric evaluation, medical consultation, diagnostic tests, and progress notes, in the event a psychiatric emergency situation occurs, or if immediate crisis stabilization is needed.

I authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse, I understand that it cannot be re-disclosed by a recipient without specific consent. I authorize disclosure of information which refers to treatment or diagnosis of HIV infection, ARCS or AIDS. I understand I may review such information prior to its release (the review may be supervised).

I understand that individuals about whom such disclosures have been made encountered discrimination from others in the areas of employment, housing, education, life insurance, and social and family relationships. I understand that I can refuse to disclose some information in my treatment records, but if I do so, could result in improper diagnosis, improper treatment, denial of coverage on claims, or other insurance and adverse consequences. I further understand that such information to be disclosed may include treatment of psychiatric, substance abuse and HIV/AIDS related illnesses. I can revoke all or part of this authorization, in writing at any time by delivering a written, dated and signed notification to the office of Dr. Pedro Guimaraes. I am entitled to a copy of this authorization, upon request. I can cross out any provision on this form with which I disagree. This authorization is to remain effective until ___________ **(date not to exceed one year).** I authorize future disclosures regarding these records in the same individuals and or entitles during this time period.

________________________________ ____________________________ _________

Print Patient Name/Authorized Representative   Signature of Patient/Authorized Representative   Date