VENTURA COUNTY MEDICAL CENTER (VCMC) VENTURA COUNTY BEHAVIORAL HEALTH DEPARTMENT (VCBHD) CONSENT TO OBTAIN OR RELEASE CONFIDENTIAL INFORMATION

Information to be released from:	Client Identifying Information:		Information to be released to:	
Ventura County Behavioral Health	Name		BEACON HEALTH STRATEGIES AND HSA	
	DOB			
Attn.:	SS #		Attn.:	
I, hereby consent to and authorize the V.C.M.C., V.C.B.H.D. to:				
☑ Obtain from the above named individual/agency ☑		⊠ Release to the	☑ Release to the above named individual/agency	
The following specific types of information:				
☐ Admission/Psychiatric Assessment ☐	☑Entire Record	☐ Social History	☐ Medication	
☐ Diagnosis	☐ Health History	☐ Psychological/ ☐ Lab Tests		
☐ Discharge Summary	☐ Treatment Plan(s) ☐ Vocational Testin		ing Other	
For the Purpose of: <u>facilitation of assessment and treatment</u>				
This information will be provided in the following format: ⊠ written ⊠ verbal □ audio &/or visual				
This consent can be revoked by the undersigned at any time and if not revoked earlier, it shall terminate:				
\square Six (6) months from date signed		☑ Two (2) years from date signed		
<u>X</u> Dated		X Signature		
Dated				
Witnessed by		Client, Parent, Guardian or Authorized Rep. of Client		
Date sent: Preparer's signature				
Material received by:				
If this consent is revoked earlier than time period indicated above: Date Terminated				
If Summary only, state reason:				
State law and departmental regulation prohibit making any further disclosure of this information without informed, written consent from the person to whom this information pertains. See California Welfare and Institution Code Section 5328 and Evidence Code Section 1014. A faxed copy of the signed consent to release information is as valid as an original.				

Ventura County Behavioral Health Mental Health Services

Confidential Patient Information Welfare & Institutions Code 5328 and Evidence Code 1014 CONSENT TO
OBTAIN OR RELEASE
CONFIDENTIAL
INFORMATION

Name:

ID #:

Site: