AUTHORIZATION FOR RELEASE OF OFFENDER CENTRAL FILE*

(Excluding Confidential Section and DOJ Records of Arrests and Prosecutions)

All sections must be completed for the authorization to be honored.

I. Inmate Information

Last Name: _____ First Name: _____ M.I.: _____

CDC #: _____ Date of Birth: _____

Institution: _____ Housing Assignment: _____

II. 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 to release the below central file and protected health information pursuant to this authorization.

Name: San Francisco District Attorney's Office, Post Conviction Review Unit

Address: 350 Rhode Island Street, Suite 400N City/State/Zip: San Francisco, CA 94103

Phone: (628) 652-4000 Email: sfda.1172.1@sfgov.org

III. Purpose for Release or Use of the Information

[45 C.F.R. § 164.508(c)(1)(iv)]

Purpose: _____

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

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

This is a one-time authorization for release of my central file and protected health information for the purpose described in Section III above. This authorization shall expire after the records requested have been released to the person or organization named in Section II. Any future release will require completion of a new “Authorization for Release of Offender Central File”.

*For Release of Medical Records, CDCR Form 7385 is Required

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V. Authorization Information

I understand the following:

1. The release of my central file may include the release of information related to: medical, dental, mental health, HIV, substance abuse/alcohol, psychotherapy notes, genetic testing and communicable diseases.

2. I authorize the use or disclosure of my individually identifiable protected health information as described above for the purpose listed. I understand this authorization is voluntary.

3. I have the right to revoke this authorization. To do so, I must send a signed letter to the party in Section II informing them that I wish to cancel this authorization which will stop further release of the protected health information in my central file. [45 C.F.R. § 164.508(c)(2)(i)]

4. I am signing this authorization voluntarily and understand that my health care treatment will not be affected if I do not sign this authorization. [45 C.F.R. § 164.508(c)(2)(ii)]

5. Under California law, the recipient of the protected health information under the authorization is prohibited from further disclosing the protected health information, except with a written authorization or as specifically required or permitted by law. [Civ. Code § 56.13]

6. Under Federal law, an individual's access may be denied if the protected health information was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information. [45 C.F.R. § 164.524(a)(2)(v)]

7. I have the right to receive a copy of this authorization. [45 C.F.R. § 164.508(c)(4) & Civ. Code § 56.11(i)]

V. Authorization to Release Offender Central File (Excluding Confidential Section and DOJ Records of Arrests and Prosecutions)

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

Offender Name: _____ CDC #: _____

Offender Signature: _____ Date: _____

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