I authorize (releasing party):	**To disclose to (receiving party):**
Name San Diego County Sheriff's Department	Name ______________________
Address 5530 Overland Ave. Ste.370	Address ______________________
City/State San Diego, CA 92123	City/State ______________________
Phone 858-974-5848 Fax 858-974-5854	Phone __________ Fax __________

By paper, oral, and electronic means any and all of my medical records listed below. Mental Health, Alcohol/Drug & HIV information will not be released unless specifically requested.

- ☐ **MEDICAL** injuries, illnesses, conditions
- ☐ **MENTAL** illnesses, conditions
- ☐ **HIV** test results
- ☐ **ALCOHOL/DRUG** abuse

PURPOSE for release: ☐ Continuity of care ☐ Other: ______________________

SPECIFIC records to release: ☐ HIV test results ☐ Other: ______________________

NOTICE: I understand that the medical information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations (HIPAA). I further understand that the Sheriff's Department may not condition treatment on whether I sign this authorization. California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained or unless such disclosure is specifically required or permitted by law.

EXPIRATION: This authorization will expire automatically in 3 months or on: __________

REVOCATION: I may revoke this authorization at any time by notifying the issuing party in writing.

COPY: I authorize the use of a facsimile or photocopy of this form. I may receive a copy of this authorization. (Initial here for copy): _________ Copy given: ☐ Yes ☐ No

Social Security Number	AKA	CDC Number

Patient's Signature (or Other Representative)	JIMS Number	Date of Birth	Date

If not signed by patient, specify basis for authority to sign:

- ☐ Attorney-In-Fact For Health Care (Attach a copy to this authorization)
- ☐ Other (Attach a copy to this authorization): ______________________

SAN DIEGO COUNTY SHERIFF'S DEPARTMENT
MEDICAL SERVICES DIVISION
Authorization To Release Patient Medical Record

☐ GBDF/FAC8 ☐ EMRF ☐ LCDRF ☐ SBDF ☐ SDCJ ☐ VDF

Patient's Name: ______________________

D.O.B: ______________________

Form **J224** Rev 08/2014

Booking Number: ☐☐☐☐☐☐☐☐

Date (MM-DD-YY): ☐☐ – ☐☐ – ☐☐