BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
DEPARTMENT OF CONSUMER AFFAIRS • CALIFORNIA BOARD OF OCCUPATIONAL THERAPY
1610 Arden Way Suite 121, Sacramento, CA 95815
P (916) 263-2294 F (916) 567-9534 E cbot@dca.ca.gov W www.bot.ca.gov

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Name:_____

SSN: _____ Date of Birth: _____

I, the undersigned, hereby authorize:
(Please list one Occupational Therapist (OT) or Occupational Therapy Assistant (OTA) per box)

OT / OTA # _____
Please circle one *Last name* *First Name* *MI*

Address:_____

Phone Number(s):_____

Treatment Date(s):_____

OT / OTA # _____
Please circle one *Last name* *First Name* *MI*

Address:_____

Phone Number(s):_____

Treatment Date(s):_____

To provide records in the course of my treatment, including occupational therapy, medical, psychiatric, alcohol and drug abuse patient records (original and/or electronic/computer generated) **to the CALIFORNIA BOARD OF OCCUPATIONAL THERAPY (Board)**, a licensing and regulatory agency. The disclosure of records, authorized herein, is required for official use, including investigation and possible administrative

proceedings regarding any violations of the laws of the State of California. This authorization shall remain valid until the Board completes its investigation and proceedings, if any, arise out of the investigation.

A copy of this authorization shall be valid as the original. I understand that I have a right to receive a copy of this authorization if requested by me. I understand that I have the right to revoke this authorization by sending written notification to the Board, located at 1610 Arden Way Suite 121, Sacramento, CA 95815. My written revocation will be effective to the extent that such persons have acted in reliance upon this authorization. I understand that the recipient of my information is not a health plan or health care provider and the released information may no longer be protected by federal privacy regulations.

A copy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization if requested by me.

Signature: _____ _____
Patient Date

Or:

_____ _____
Legal Representative Relationship Date

NOTE TO THE PROVIDER: This release is compliance with the requirements of HIPAA and Civil Code Section 56.11.