County of San Bernardino Preschool Services Department
AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION
FOR IMMEDIATE NEED VOUCHER

Name of Caregiver: _____	Date of Birth: _____ (Month/Date/Year)
Sex: ☐ Male ☐ Female	COPA ID: _____

Completion of this document authorizes the release, disclosure, and/or use of information about you. Failure to provide all information may invalidate this Authorization.

USE AND DISCLOSURE OF INFORMATION

I hereby authorize Preschool Services Department to release to:

(1) Name: Human Services Administration
Address: 150 South Lena Road, San Bernardino, CA 92415-0515
Phone/Fax Number (909) 388-0278 (phone) / (909) 388-0233 (fax)

and

(2) Name: Children's Fund
Address: 825 East Hospitality Lane, Second Floor, San Bernardino, CA 92415-0132
Phone/Fax Number (909) 387-4949 (phone) / (909) 383-9755 (fax)

and

(3) Name: Human Services Audition Division
Address: 825 East Hospitality Lane, First Floor, San Bernardino, CA 92415-0132
Phone/Fax Number (909) 383-9600 (phone) / (909) 383-9610 (fax)

The following information:

Minor's personally identifiable information and/or protected information such as name, address, telephone number, date of birth, gender, ethnicity, COPA ID number and parent/guardian's name related to an immediate need voucher received.

PURPOSE

Purpose of requested use is: Information shall be provided for the purpose of tracking and auditing immediate need vouchers.

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To Agencies Receiving this information: This information is protected by state and federal laws and should not be given to anyone else not included on this Authorization without a new authorization from the client, unless otherwise authorized by law.

EXPIRATION

This Authorization expires [insert date]: _____

MY RIGHTS

- I may refuse to sign this Authorization. It will not affect my ability to get treatment but will affect my ability to receive a voucher.
- I have a right to receive a copy of this Authorization.
- I may revoke this authorization at any time, but must do so in writing and submit it to the following address: _____

  _____

My revocation will take effect upon receipt, to the extent that others have acted on your original Authorization and already completed the release of information. Unless indicated, no other information will be released from the date of the revocation.

Information released by this Authorization could be re-released by whoever receives it, and the re-release in some cases not protected by California law and may no longer be protected by federal confidentiality.

SIGNATURE

Date: _____ Time: _____ ☐ am ☐ pm

Signature: _____

(Caregiver Signature)

If signed by someone other than the client, state your name and legal relationship to the client:

Name _____

Relationship: _____