SANTA BARBARA COUNTY SHERIFF'S OFFICE

Custody Operations – Inmate Grievance Form

Staff Use Only
CID#_____
LOG#_____

Name: _____ **Booking#:** _____ **Housing:** _____

Date: _____ **Check One:** ☐ **Grievance** ☐ **Appeal** **Log#:** _____

Jail policy is that a written response will be provided within 15 days of receipt of the grievance.

If this grievance is related to the Medical, Psychiatric/Mental Health, Dental, or Vision care provided to you during this incarceration, you **must** complete and sign the release form on the reverse side of this sheet. Failure to sign the release form will limit the Sheriff's Office ability to adequately respond to and/or resolve the issues for which you are grieving. The release authorization on the back of the **white sheet** is the sole original authorization.

---------- ***Do not write below the dotted line for Staff use only*** ----------

Rec'd by: _____ **Date:** ___/___/___ **Resolved on scene by:** _____ **Date:** ___/___/___

Reply: _____

Reviewing Supervisor: _____ **Date:** ___/___/___

If not resolved, routed to: _____ **By:** _____ **Date:** ___/___/___

Administrative review: _____ **Date:** ___/___/___

To: Corizon Health, Santa Barbara County Jail

Patients Name: _____ Date of Birth: _____/_____/_____
First Last MI

CID #: _____ Alias: _____

HIPAA Authorization for Release of Health Information

I, _____, hereby authorize Corizon Health to release any and all of my health information related to services provided to me during this incarceration to the Santa Barbara County Sheriff's Office, or any Deputy, Custody Deputy, Investigator, the Grievance Coordinator, or any other duly appointed and identified agent of the Santa Barbara County Sheriff's Office for the purpose of investigating and resolving the complaints detailed in the Grievance Form included on the reverse of this release.

The sole purpose of this release is to allow a response to my complaint(s) with sufficient detail to answer or resolve my concerns as detailed in the attached grievance. I am aware that my information may contain information that otherwise would be considered confidential.

I have thoroughly read this release, and by my initials here (_____) indicate that I am aware of my **special rights to keep my records confidential**, especially any records pertaining to my Psychiatric/Mental Health/Psychological history, or records revealing alcohol or drug abuse history, or treatment provided under the **Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Lanterman-Petris-Short Act (LPS)**. With this special protection in mind, and by my initials above and signature below, I waive these rights so that I may be able to provide the Santa Barbara Sheriff's Office with my records and/or information. I further understand that there is the potential for this information to be re-disclosed by the recipient and that Santa Barbara County is not responsible for re-disclosure. California law prohibits health care providers and health plans from re-disclosing information except with my written authorization or as specifically permitted by law. By my initial above, and signature below, I also authorize re-disclosure of my information and/or records as necessary. I hereby also release records custodians from any liability that may arise from such disclosure.

I understand that the County does not condition my eligibility for services on my signing this form, and that I may revoke this authorization by writing the Sheriff's Office, or any Deputy, Custody Deputy, Investigator, the Grievance Coordinator, or any other duly appointed and identified agent of the Santa Barbara County Sheriff's Office. A copy of this authorization is included on my copy of the grievance form.

This authorization is intended to be valid for a period of ninety (90) days from the date it is signed, or upon conclusion of this review/investigation, whichever is earlier, and copies of this authorization have the same force and effect as the original.

Executed at: Santa Barbara County Jail

Signature: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____ Time: _____

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