SANTA BARBARA COUNTY DEPARTMENT OF Behavioral Wellness
A System of Care and Recovery

Inter-Agency / Multi-Disciplinary Team Services Authorization for Use, Exchange And Disclosure of Confidential Substance Use Disorder (SUD) Information

CLIENT NAME: _____ CLIENT NUMBER: _____
(Last, First, M.I.)

CLIENT SSN: _____ DATE OF BIRTH: _____ PHONE #: _____

CLIENT ADDRESS: _____
(Residence / Street) (City) (State) (ZIP Code)

Completion of this document authorizes the use, exchange and/or disclosure of confidential health information. This form must be completed before any protected health information can be used, disclosed or exchanged about you (your child).

I give my permission to the individuals identified below who are directly involved in my (my child's) care or the provision of services at the following agencies/members of the Santa Barbara County Select A Program multi-disciplinary team:

Treatment Providers: (*You do not need the name of individual participant(s) within the entity to share PHI with treatment providers.*)

- ☐ **Select Entity / Individual**
- ☐ **Select Entity / Individual**
- ☐ **Select Entity / Individual**
- ☐ Other: _____
- ☐ **Select Entity / Individual**
- ☐ **Select Entity / Individual**
- ☐ **Select Entity / Individual**
- ☐ Other: _____

NON-Treatment Providers: (*You MUST PROVIDE name of individual participant(s) within the entity, which does not have a treating provider relationship to share PHI.*)

- ☐ **Select Entity / Individual** **Name(s):** _____
- ☐ **Select Entity / Individual** **Name(s):** _____
- ☐ **Select Entity / Individual** **Name(s):** _____
- ☐ Other: _____ **Name(s):** _____
- ☐ Other: _____ **Name(s):** _____

Purpose:

To use, exchange, or disclose confidential information, including all health information pertaining to my medical history; assessment and treatment received, only to the extent necessary, about me (my child) within the program and among the members of my (my child's) multi-disciplinary team/agencies checked above. The purpose is to enable the program team to evaluate eligibility or continued eligibility for assistance or benefits, and to assess, provide, and coordinate health care appropriate to my (my child's) needs.

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Information To Be Used, Disclosed or Exchanged In Discussion and/or Paper Copies Includes

☐ Physical Health

☐ All health information pertaining to my (my child's) medical history, mental or physical condition; diagnosis; medications; and treatment received.

AND

I understand this health information may include protected under strict California law and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse information that is more sensitive in nature and may have special privacy protections provided by the federal alcohol and drug abuse regulations [42 CFR, Part 2]; and/or the Lanterman-Petris Short Act [CA Welfare & Institutions Code 5328]; and that by signing this form, I am specifically authorizing the use or disclosure of following information relating to (*check as appropriate*):

☐ Mental Health treatment information

☐ HIV/AIDS related information (including AIDS related diagnosis and/or treatment)

☐ Substance Use Disorder (including Alcohol) treatment information (*substance use disorder information subject to this authorization must be explicitly described*): _____

_____

OR

☐ I only authorize the use, exchange or disclosure of the following information (*describe, including any dates*):_____

_____

This Authorization Applies To Service Dates, Date Range, Or Time Frame Of Information

Services to be disclosed: From: _____ To: _____

Expiration – *YOU MUST SELECT* *(one of the following for the authorization to become valid)*

☐ Unless specified otherwise, this authorization will remain in effect for a period of one year from the signatory date unless termination of treatment or written revocation occurs prior.

☐ This authorization expires as specified: _____

Special Privacy Considerations (*if applicable*)

NOTE: The following types of information will not be released unless specifically authorized with an additional signature and date. With my signature below, I **specifically authorize** the use and/or disclosure of information relating to:

☐ Sexually transmitted or "communicable" diseases (includes hepatitis and venereal diseases)

☐ Human Immunodeficiency Virus (HIV) **Test Results**

_____ _____

Signature of client, parent, or authorized representative (if applicable) Date

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Client Rights And Responsibilities

- I understand this authorization is voluntary and that my refusal will not affect my ability to receive services from the Department of Behavioral Wellness and contracted providers.
- I understand that I may revoke this authorization at any time by submitting it, in writing, to the Multi-Disciplinary Team or the Behavioral Wellness Department Health Information Management Administrator, Fax No: (805)681-5294, Attn: HIM Administrator. My revocation will take effect upon receipt, except to the extent action has already been taken in reliance upon it.
- I understand that minors 12 years of age and older may be required to sign the authorization.
- I understand that information used or disclosed in accordance with this authorization may no longer be protected by the Health Insurance Portability & Accountability Act of 1996 (HIPAA), and could be used or re-disclosed by the receiving party. However, as noted below, all or part of these records will continue to be protected under state and federal regulations governing the privacy and confidentiality of mental health and/or alcohol, drug records.
- I understand if a general designation is indicated, and consistent with 42 CFR Part 2, I must be provided with a list of entities to which this information has been disclosed pursuant to this general designation.
- I understand my right to inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. I have a right to receive a copy of this authorization form (Copy Provided ☐ Yes ☐ No).
- I understand information used, exchanged and/or disclosed pursuant to this authorization will not be re-disclosed by members of the multi-disciplinary teams/agencies except as required or permitted by law or pursuant to additional authorization from me.

Notice To Recipient(s) Protected Health Information

Please note Federal Confidentiality Rules (42 CFR Part 2) and California Law prohibit further disclosure of medical; substance abuse and/or mental health records, unless further use or disclosure is expressly permitted by obtaining a written authorization from the person to whom it pertains. A general authorization for the use or disclosure of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

Authorizing Signature (*Please do not sign this form until the above information is completed.*)

_____ _____
Signature of client, parent, or authorized representative — Date

_____ _____
Signature of Witness (required for "X", Illegible, or foreign character signatures) — Date

Signed By: ☐ Client ☐ Parent ☐ Authorized Representative(*relationship*) _____

Failure to provide all or part of the requested information could result in delay of services

CLIENT NAME: _____ **CLIENT NUMBER:** _____