San Luis Obispo County Health Department
Authorization (Consent) for Disclosure of Substance Use Disorder (SUD) Records for Billing

Last, First, MI Name: MR#:

Last 4 digits of SSN: XXX-XX- DOB:

SUD information is protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164, and cannot be disclosed by the San Luis Obispo Behavioral Health without written authorization (consent) unless otherwise provided for by the regulations.

What We Are Requesting

We are requesting your permission to share SUD Information about you so that San Luis Obispo County Behavioral Health can bill for and obtain payment/reimbursement for your care.

Authorization

I authorize San Luis Obispo County Behavioral Health to disclose to _____ (named insurer, insurance plan or program, or other payer) the following information:

____ (Initial) SUD treatment or services
____ (initial) Diagnosis
____ (initial) Treatment start and stop dates _____ to _____
____ (initial) Other:_____
_____

Purpose

The purpose of a disclosure pursuant to this authorization/consent is so that San Luis Obispo County Behavioral Health can bill my insurance or other payer so that it can obtain payment/reimbursement for my care.

Expiration

This authorizations will expire on _____(Name expiration date; event or Designation of Ineligibility).

Revocation

You may cancel this authorization before it expires by contacting:

SLO County Privacy Officer: 2180 Johnson Ave., San Luis Obispo, CA 93401
Or via email at privacy@co.slo.ca.us; or call (855) 326-9623

Refusal to Authorize the Release of SUD Billing Information

☐ By initialing the "Refusal to Authorize the Release of SUD Billing Information" section, patients will still be able to access and receive usual care and services from San Luis Obispo County Behavioral Health, **EXCEPT** that patients will be assuming the financial responsibility for the costs of treatment and services within San Luis Obispo County Behavioral Health for their substance use disorders.

If the person receiving care is a minor under 12 years of age, then a parent or legal guardian acknowledges having read and understood this document and authorizes (consents) such release.
Both the minor and the parent/legal guardian must sign below.
Minors aged 12 and older may consent to treatment and authorize the release of information regarding their treatment themselves without parental permission, in which case only the minor must sign below.

I understand I have the right to receive a copy of this authorization (consent).

Client Signature:_____**Print Name:**_____**Date:**_____

Representative Signature:_____**Relation:**_____**Date:**_____