San Luis Obispo County Health Department
Consent for the Disclosure, Use and Exchange of Confidential Information for Criminal Justice Consent

Last, First, MI Name: MR#:

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

☐ **By Initialing, I consent that <u>my entire medical record</u> can be Received, Shared and Disclosed from and between my Behavioral Health Information and the following Treatment/Non-Treatment Providers.**

Legal medical record includes the following:
CalOMS Admission and Discharge, Diagnostics, Any Assessments, re-assessments or Screenings, Lab and drug testing and results, Discharge summaries/Plans, Treatment Plans, Progress Notes, including group notes, and Physician progress notes, Attendance records, Service Requests, Referrals, Physical examinations, Justification for continued treatment.

OR

☐ **By Initialing, I consent to <u>only certain portions</u> of my Behavioral Health Information medical record can be Received, Shared and Disclosed from and between my Behavioral Health Information and the following Treatment/Non-Treatment Providers. (Indicate specifics):**

_____
_____
_____

San Luis Obispo Behavioral Health Program will only disclose to whom you have given consent in writing.

Initials	Organizations	Initials	Organizations
	Social Services		Bryan's House Recovery Home, Inc.
	Sheriff (Bailiff)		Residential Treatment Facilities
	County Council		Recovery Residences
	County Superior Court		Court Appointed Special Advocates (CASA)
	Testing Laboratories		Attorney(s):
	School		Family Members:
	CAPSLO Direct SVCS/Parent Education		Veterans' Service Officer
	Tri-Counties Regional Center		Foster Parent
	Probation		Transitions MH Assoc (TMHA)
	Parole		Court (List County):
	San Luis Obispo Mental Health Services		District Attorney
	Sierra Mental Wellness Group		Other:

	Family Care Network, Inc.		Other:
	Seneca Center		Other:
	Child Development Center		Other:
	Wilshire Foundation Community Services		Other:

Purpose and Limitations for the Use or Release of the Information

I understand that the purpose for the ongoing disclosure and sharing of my health information is to allow for coordination of care/referrals between any treatment or non-treatment providers listed in this consent.

☐ **I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal & effective termination or revocation of my release for confinement, probation or parole, or other proceeding under which I was mandated into treatment. I understand that generally Behavioral Health Information Program may not condition my treatment on whether I sign a consent form, but in certain limited circumstances I may be denied treatment if I do not sign a consent form.**

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

- **I consent to the use and/or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that I do not need to sign this consent to receive treatment, enroll in services or for payment for my health care. If my refusal to sign affects San Luis Obispo County's ability to provide services, San Luis Obispo County will try to offer services under another program.**
- **PART 2-Confidentiality of Substance Use Disorder Patient Records are protected under Federal regulations governing confidentiality under 42 C.F.R Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R Part 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations.**
- **I have the right to receive a copy of this consent.**

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

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

Staff Signature:_____**Print Name:**_____**Date:**_____