San Luis Obispo County Health Department
Consent for the Disclosure, Use and Exchange of
Confidential Information for Joint Medical Records

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 Substance Use Disorder Program Health Information and the following Treatment providers initialed below.**

OR

☐ **By Initialing, I consent to <u>only certain portions</u> and or date range of my Substance Use Disorder Program Health Information medical record can be Received, Shared and Disclosed from and between my Substance Use Disorder Program Health Information and the following Treatment providers initialed below (Indicate specifics)**
_____(Date) to _____(Date)

_____

_____

_____

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 Counseling Notes, Physician/Prescriber Progress Notes, Attendance Records, Service Requests, Referrals, Physical Examinations, and Justification for Continued Treatment.

San Luis Obispo Behavioral Health-Substance Program will disclose nothing outside of our treatment program, including for treatment or payment. If you want us to disclose to anyone outside of your substance use disorder team for treatment or payment purposes, you must give your consent in writing.

Initials	Organizations	Initials	Organizations
	San Luis Obispo Mental Health Services		Other:
	Sierra Mental Wellness Group		Other:
	Family Care Network		Other:
	Seneca Center		Other:
	Child Development Center		Other:
	Wilshire Foundation Community Services		Other:
	Bryan's House		Other:
	Wellpath		Other:
	Residential Care Facilities		Other:
	Tri-Counties Regional Center		Other:
	Transitional Mental Health Association		

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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 between any treatment providers listed in this consent.
By Initialing, this Consent to receive, share, and disclose: **☐ Will not expire until the end of treatment** **OR** **☐ Will expire on (Enter date not to exceed 1 year) or specific event: _____**
• **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.** • **I have the right to revoke this consent by sending a signed notice stopping the consent to:** **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** • **The Notice of Privacy Practices provides instructions if I choose to revoke my consent and includes limitations of my revocation. This consent expires on listed date or event unless revoked sooner and I understand that some information may have already been disclosed prior to my revocation.** • **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:_____**