County of San Luis Obispo Behavioral Health
Coordinated Care Consent

Client Name _____Client ID # _____

Coordinated Care Authorization

By signing this form, you authorize certain organizations and individuals to use and share your health and other personal information for purposes related to your treatment and care. They will be able to share your information through an electronic health record system maintained by the California Mental Health Services Authority called SmartCare.

1. **Who will share my information if I sign?**
   By signing, your information may be shared by and with any of the following that provide services to you (your providers) and which are connected to SmartCare:

   - County Health Agency Staff and contracted organizations and individual providers.

   Your providers also include any health insurers that provide you with coverage, including any of your mental health plans.

2. **If I sign, will my providers be able to use and share my information for any reason?**
   No. If you sign, you authorize your providers to use and share your information only for limited purposes. You authorize your providers to use and share your information for purposes of treatment, payment, and health care operations only. For example, your providers can use your information to provide you with medical or behavioral health care, to coordinate your care, to determine how much should be paid for services provided to you, or to improve the quality of care.

3. **What types of information about me may be shared if I sign?**
   Your providers may share the following types of information about you:

   - Behavioral Health information, such as any mental health conditions or alcohol or drug use disorders you may have, which could include information on your substance use history and medications, diagnoses, and drug test results.

- Medical information as it relates to your Behavioral Health record, such as information about illness, injuries, medical treatments, allergies, medications, blood tests, and your HIV status.

4. **Can I obtain a list of providers who saw my information?**
   Yes, we can provide you with a list of those who looked at information about you. Just ask us.

5. **Can the providers who see information about me in SmartCare disclose it to others?**
   Yes, if permitted by state and federal laws. In some cases your information may no longer be subject to federal privacy laws once it is shared. Certain substance use disorder information about you may be redisclosed if permitted under the Health Insurance Portability and Accountability Act, except that you do not authorize the disclosure of such information for uses in civil, criminal, administrative, or legislative proceedings against you.

6. **When does my authorization expire?**
   You authorize your providers to access your information for 1 year after the date you sign, unless you indicate below that you want the authorization to last a different period of time.

7. **Can I change my mind and revoke my authorization later?**
   Yes, you have a right to revoke this form at any time. If you want to revoke, you should contact us at 800-838 -1381. If you revoke, some of your providers will still be legally permitted to see some information about you via SmartCare in certain circumstances, but other information (such as your substance use disorder information) typically will be inaccessible to them.

8. **If I am a parent or guardian, can I sign on behalf of my child who is under 18?**
   Yes, you may do so by including your name as the Legal Representative of your child and by signing below. Your child should also sign if your child is 12 or older since your child has the right to authorize disclosure of certain types of information. If you sign on behalf of a child, the form will expire when your child turns 18.

Client Name _____Client ID # _____

9. **Do I have to sign this?**
   No, signing this form is voluntary, and declining to sign this form will not impact your ability to get medical care, mental health or substance use treatment, health insurance, or any government benefits. If you don't sign, some of your providers still may see some of your information in SmartCare in accordance with the law, but the information accessible to them will be more limited than if you provided authorization.
10. **Can I have a copy of this form?**
    Yes, you have a right to a copy of this form. Just ask us for one.

Client Information

First Name _____ Last Name _____

Date of Birth _____ Email _____

Contact _____ Relation of contact to client _____

Phone Numbers

Phone Number _____ ☐ DNC ☐ DNLM

Alternate Number _____ ☐ DNC ☐ DNLM

Addresses

Client Address _____

Mailing Address if different _____

County of San Luis Obispo Behavioral Health
Coordinated Care Consent

Client Name _____Client ID # _____

Consent

I give consent for sharing of information across all services within the County of San Luis Obispo Behavioral Health behavioral health network.

☐ Yes ☐ No

☐ 12 months ☐ 6 months ☐ End of Agency Treatment

Start Date _____ Expiration Date _____

Client Identified Restrictions

Restricted Staff _____

Details on any other restrictions of sharing my data. This will prompt a review by the County of San Luis Obispo Behavioral Health Privacy Officer. This does not guarantee the restriction of this data as specified in the text.

_____

_____

Client Signature _____ Date_____

Parent / Guardian Signature _____ Date_____

Relationship _____

Staff Signature _____ Date_____