County of San Luis Obispo Behavioral Health
Multi-Party Release of Information

Client Name_____ Date of Birth _____ Client ID _____

AUTHORIZATION TO OBTAIN/DISCLOSE PROTECTED HEALTH INFORMATION

General

Authorization for the Disclosure of Protected Health Information

By signing this form below, I am authorizing the disclosure of my protected health information to one or more persons for the purposes specified on this form. If I agree, I understand this may include information about any substance use disorder treatment I have received.

Release To/Obtain From

Name or other specific identification of person(s) authorized to receive/make the requested use or disclosure.

☐ Release To ☐ Obtain From

Initial whom we can release to or obtain from:			
	SLO County Counsel		Parole
	SLO County District Attorney's Office		Pharmacy
	SLO County Jail Custody Staff		Probation
	SLO County Sheriff (Bailiff)		School
	SLO County Superior Court		SLO City Attorney's Office
	SLO County Social Services		SLO Police Department
	Attorney(s):		Sober Living Environments
	5-Cities Homeless Coalition		Transitional Mental Health Association
	CAPSLO Direct SVCS/Parent Education		Tri-Counties Regional Center
	Court Appointed Special Advocates (CASA)		Veterans' Service Officer
	Family Members (Specify):		Other:
	Foster Parent		Other:

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Purpose of Disclosure

☐ Treatment/Care Coordination ☐ Other _____

Preferred Method of Delivery

☐ Paper ☐ Encrypted Email ☐ Unencrypted Email

☐ Fax ☐ Encrypted USB ☐ In-Person Drop-Off/Pick-Up

☐ Other: _____

Expiration

☐ 1 time disclosure ☐ 6 months ☐ One (1) Year

Start Date _____ **End Date** _____

Information to be used or disclosed

The information that can be disclosed under this authorization includes the following, if available

Type: ☐ MH ☐ SUD **OR** ☐ MH and SUD

☐ All Records ☐ Acknowledgement of Treatment

☐ School Records/Reports/IEPs ☐ Intake/Admission Information

☐ Psychological Evaluation(s) Reports ☐ Medications Prescribed

☐ Discharge Summary/Plan ☐ Progress Review /Summary

☐ Screening Assessment(s) ☐ Treatment Plan(s) ☐ Progress Notes

☐ Medical History, Lab results, Immunization Records

☐ Other _____

Client Name_____ Date of Birth _____ Client ID _____

Records Start Date _____ Records End Date _____

Restrictions:

_____

_____

_____

Terms

I understand:

- Under state and federal confidentiality provisions only the information specified can be released.
- The recipient(s) of my information may disclose it to others. I understand that in some cases my information may no longer be subject to privacy laws once it is disclosed.
- I may revoke this authorization at any time, but a revocation will not apply to information that has previously been released.
- If not otherwise specified, this authorization will expire in one (1) year from the date of signature.
- This authorization is voluntary, and that declining to sign this authorization will not impact my ability to get medical care, health insurance, or any government benefits. I have been given the chance to ask questions and receive answers pertaining to this document.
- I have a right to a copy of this form.

Signing for a Child

- I understand that if I am signing this form on behalf of a minor, I should include my name as the "Legal Representative" of my child, and that I should sign this form. If my child is 12 or older, my child should also sign.

By signing, I authorize the disclosure as described above.

Agency Contact Information

County of San Luis Obispo Central Health Information at **805-781-4724**

Program _____ Attention _____

Address _____

City _____ State _____ Zip Code _____

Copy Given to Client ☐ Yes ☐ Declined a copy

Agency Staff _____

ID verified by ☐ Driver's License ☐ Other Picture ID ☐ Known to Agency

Information about HIV/AIDs and Substance Abuse Treatment –

Information about HIV/AIDs status and treatment for Substance Abuse will not be released without your specific permission. Do you authorize these releases of information to the person/organization listed above?

Alcohol/Drug Abuse:

☐ I authorize the release of information relating to referral and/or treatment for alcohol and drug abuse.

☐ I **PROHIBIT** the release of information relating to referral and/or treatment for alcohol and drug abuse.

Client Name_____ Date of Birth _____ Client ID _____

HIV/AIDS/Sexually Transmitted Disease/Communicable Disease

☐ I authorize the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.

☐ I **PROHIBIT** the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.

Client Signature _____ Date _____

Parent / Guardian /
Legal Representative Signature _____ Date _____

Relationship _____

Staff Signature _____ Date _____