County of San Luis Obispo Behavioral Health

Multi-Party Criminal-Involved &/or Court-Mandated Programs Release of Information

Client Name_____ Date of Birth _____ Client ID _____

AUTHORIZATION TO OBTAIN/DISCLOSE PROTECTED HEALTH INFORMATION

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 District Attorney's Office
	SLO County Jail Custody Staff
	SLO County Sheriff (Bailiff)
	SLO County Superior Court
	Parole
	Probation
	Attorney(s):
	Other:

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 _____

Records Start Date _____ Records End Date _____

Restrictions:

_____

_____

<u>JUSTICE PROGRAMS ONLY</u> - PLEASE INITIAL ONLY IF APPLIES

☐ **I understand if I do not sign a consent for release of my records to the Criminal Justice Program which required me to participate in a specific County Behavioral Health treatment program, County Behavioral Health shall instead provide general behavioral health treatment services to me, and I may be jeopardizing my continued participation in a Criminal Justice Program which requires my participation in treatment. I further understand that if I do consent to release of my records to such Criminal Justice Program, such consent will remain in effect and cannot be revoked by me until there has been a formal & effective termination or revocation of my release from confinement, probation or parole, or other proceeding under which I was mandated into this treatment.**

Terms

- 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 have a right to revoke this form at any time – excluding an early revocation in regard to a Criminal Justice Program, as noted above – by contacting County of San Luis Obispo Health Agency. I understand that if I revoke, the recipient(s) of my information may keep the information that they received about me prior to the date I revoked.

- 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.

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 _____