County of San Luis Obispo Behavioral Health
Release of Information - CRIMINAL JUSTICE

Client Name_____ Client ID _____

AUTHORIZATION TO OBTAIN/DISCLOSE PROTECTED HEALTH INFORMATION

General

The County Behavior Health Services abides by all federal and state confidentiality laws including HIPAA (Health Insurance Portability & Accountability Act), and 42 C.F.R Part 2. By signing this authorization, I acknowledge, accept, and agree. This information has been disclosed to you from records in which confidentiality is protected by federal law. Federal Regulations (42 CFE Part 2) prohibit the recipient from making any further disclosure of it without the specific written consent of the person to whom it pertains or except as otherwise permitted by SUD's regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Information disclosed under 42 C.F.R. Part 2 cannot be used to criminally investigate or prosecute any client with a SUD except as provided for in 42 CFR Section

Release To/Obtain From

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

☐ Organization/Provider ☐ Contact ☐ Release To ☐ Obtain From

Initial whom we can release to or obtain from:			
	SLO County Sheriff (Bailiff)		District Attorney
	SLO County Counsel		Other:
	SLO County Superior Court		Other:
	Testing Laboratories		Other:
	Testing Laboratories		Other:
	Probation		Other:
	Parole		Other:
	Court Appointed Special Advocates (CASA)		Other:
	Attorney(s):		Other:
	Sentry/Cordant		Other:
	Veterans' Service Officer		Other:
	Family Members		Other:
	Recovery Residences		Other:
	San Luis Obispo Mental Health Services		Other:
	Wellpath		Other:

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Contact Type ☐ Organization/Provider ☐ Personal Contact

Purpose of Disclosure

☐ Process insurance/third part claims (Substance Abuse Remittance Only)

☐ Care Coordination

☐ HIE (Health Information Exchange)

☐ Other _____

Expiration: Initial that you agree:

☐ **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.**

Information to be used or disclosed

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

Type: ☐ MH ☐ SUD

☐ All records ☐ Acknowledgement of treatment ☐ Billing &/OR insurance information

☐ Intake/admission information ☐ Psychological Evaluation(s) reports

☐ Medications prescribed ☐ Discharge summary/plan ☐ Progress Review /Summary

☐ Screening assessment(s) ☐ AAPS Eligibility Documents ☐ School Records/Reports/IEPs

☐ Medical History, Lab results, Immunization Records ☐ Treatment plan(s)

☐ Progress Notes ☐ Legal Documents ☐ Other _____

Records Start Date _____ Records End Date _____

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Restrictions

_____

_____

_____

Terms

- Under state and federal confidentiality provisions only the information specified can be released.

- The County Behavior Health Services cannot ensure the recipient will maintain the confidentiality of the mental health and/or SUD information authorized and released. If the person or organization obtaining this information is not a health care provider, health plan or covered under the federal privacy regulations, the information may no longer be protected by federal privacy laws including 42 C.F.R. Part 2 and could be re-disclosed.

-This authorization will be honored unless revoked in writing. Revocation may be made at any time except to the extent action has already been taken.

- Persons or organizations may not re-disclose substance abuse treatment information.

- This authorization will expire in one (1) year from the date of signature, or 90 days from the date of discharge from the agency unless one of the following is selected. 30 days, 60 days, 90 days.

- This authorization is voluntary. I have been given the chance to ask questions and receive answers pertaining to this document.

- A list of entities to which my information has been released can be provided by the County Behavior Health Services.

By checking these boxes, I agree that I have read, understand, and agree to these terms.

☐ NOTICE TO CLIENT Signing this form is voluntary and not required to receive services with the County Behavior Health Services. I understand.

☐ ACCESS TO MY RECORD: I understand I can request a copy of my record. This request will be reviewed and approved by my therapist. I understand I can also review my records with my therapist by making an appointment. This request can take 30 days to complete, and charges will apply.

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Client Name_____ **Client ID** _____

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

Program(s) participated in *(write in program)* _____

Please note –
The records released may contain alcohol and drug abuse information and/or information about Human Immunodeficiency Syndrome (AIDS), and AIDS Related Complex (ARC).

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.

Copy Given to Client ☐ Yes ☐ Declined a copy Agency Staff _____

ID verified by ☐ driver's license ☐ other picture ID ☐ Known to Agency

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Relationship _____

Staff Signature _____ Date _____