



# County of San Luis Obispo Behavioral Health

## Coordinated Care Consent

Client Name

Client ID

### **Authorization for the Disclosure of Health and Other Personal Information**

By signing this form below, you will allow 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:

- Health care providers, such as doctors, hospitals, and pharmacies.
- Mental health providers and substance use disorder providers.
- School-based providers, such as nurses, social workers, and counselors.
- California county health care agencies.
- Housing providers, that is, nonprofits that help people find a home.
- Any jails or prisons that provides services to you while you're incarcerated.
- Any child welfare agencies that are actively involved in your or your child's case.
- Your providers also include any health insurers that provide you with coverage, including any of your mental health plans.

**2. Will my providers be able to use and share my information for any reason?**

No, your providers can only use and share your information for limited purposes. Your providers may use and share 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:

- Medical information, such as information about illnesses, injuries, medical treatments, allergies, medications, X-rays, blood tests, and your HIV status.
- 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.
- School services information, such as an Individualized Education Program, and any records of medical or behavioral health services provided in schools.
- Housing service information maintained in a Homeless Management Information System, which describes services provided to some people without homes.
- Incarceration information including, if you are incarcerated, when you are scheduled to be released.
- Child welfare records, including any family reunification or maintenance plan.

**4. Can I obtain a list of providers who saw my information?**

Yes, can obtain a list of providers that have received some types of your information by contacting County of San Luis Obispo Central Health Information at (805) 781-4724

**5. Can my providers who receive my information share it with others?**

Yes, but only 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.

**6. When does my consent expire?**

Your providers will be able to access your information for 10 years after the date you sign, unless you revoke your consent earlier.



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### **Authorization for the Disclosure of Health and Other Personal Information Cont'd**

#### **7. Can I change my mind and revoke my consent later?**

Yes, you have a right to revoke this form at any time. If you want to revoke, you should contact County of San Luis Obispo Central Health Information at 805-781-4724. If you revoke, your providers still may keep any information they received about you prior to the date of revocation.

#### **8. If I am a parent or guardian, can I sign on behalf of my child?**

Yes, you may do so by including your name as the "Legal Representative" of your child and by signing the last line. Your child should also sign the first line if your child is 12 or older. If you sign on behalf of a child, the form will expire when your child turns 18.

#### **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, health insurance, or any government benefits. If you don't sign, some of your providers still may have a right to obtain some of your information under the law.

#### **10. Can I have a copy of this form?**

Yes, you have a right to obtain a copy of this form.

*By signing below, I consent to the disclosure of my information as described in this form. Further, by including my phone number below, I consent to the receipt of texts or calls to communicate with me about my consent and how my information may be shared (standard message and data rates may apply).*

### **Client Information**

First Name

Last Name

Date of Birth

Email

Contact

Relation

Client Phone #

DNC

DNLM

Client Alt. Phone #

DNC

DNLM

Client  
Address

Billing



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### **Authorization for the Disclosure of Health and Other Personal Information Cont'd**

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

Yes

No

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 to Client

Staff Signature

Date