**AUTHORIZATION FOR USE, EXCHANGE, AND DISCLOSURE OF**



**PROTECTED HEALTH INFORMATION**

**Fresno County Behavioral Health and Fresno County Behavioral Health Substance Use Disorder Treatment Provider Network**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |   | Date of Birth: |   |
| Last 4 Digits of Social Security Number: |  | Record #: |   |

|  |
| --- |
| **Name or general designation of individual (s) or entity (ies) making the disclosure:***(May include the applicable address/es)* |
|  |

**To disclose the following** [ ] substance abuse**,** [ ] medical, and [ ] mental health information as follows:

[ ]  Initial Screening [ ]  Referrals [ ]  Diagnosis [ ]  Lab Report

[ ]  Progress Report [ ]  History & Physical [ ]  Medication Record [ ]  Progress Notes

[ ]  Attendance [ ]  Assessment [ ]  Treatment Plan [ ]  Immunization Record

[ ]  Verbal or Written Exchange of Treatment Information to/from of individual or entity making the disclosure to named recipient entity (ies) or individual (s)

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Dates of information from: |   | to: |   |

|  |
| --- |
| **Name of entity (ies) or individual (s) authorized to receive and use the information:***(May include the applicable address/es)* |
|  |

**The information identified in this authorization may be disclosed for the following purpose(s):**

[ ]  Coordination/Continuity of Care [ ]  Referrals [ ]  Treatment

[ ]  Legal [ ]  Insurance [ ]  Social Security Appeal

|  |  |  |
| --- | --- | --- |
| [ ]  Disability Claim | [ ]  Other  |   |

**Rights and Warnings:**

I understand that I have the following rights and warnings with respect to this authorization:

1. I may refuse to sign this authorization. I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations.
2. I may inspect or obtain a copy of the health information of which I am authorizing the disclosure.
3. I have a right to receive a copy of this authorization and will be offered a copy.
4. Some information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not prohibited by California or federal law (e.g. the Health Insurance Portability and Accountability Act of 1996 (HIPAA)).
5. Substance use disorder information may not be re-disclosed unless another authorization for such disclosure is obtained from me, or unless specifically required or permitted by the law, or permitted by this authorization.
6. I understand that I may revoke this authorization at any time verbally or in writing to the following address: 1925 E. Dakota Avenue Fresno, CA 93726, except to the extent that the Part 2 Program or other lawful holder has already acted in reliance on it (acting in reliance includes the provision of treatment services in reliance on a valid authorization to disclose information to a third-party payer).

|  |  |  |
| --- | --- | --- |
| This authorization will expire, if not revoked before, on date |   | or upon the following |
| event or condition: |   |

If I do not specify an expiration date or event, this authorization will expire in **one year**.

|  |  |
| --- | --- |
| I have been provided a copy of this form on:  |   |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date: |   |
| Name: |   | Telephone number: |   |
| Address: |   |

 If signed by a person other than the patient, indicate relationship:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| [ ]   | Parent/legal guardian of minor  | [ ]   | Conservator | [ ]   | Other: |  |
| **Revocation:** |
| [ ]  I revoke this authorization | Signature: |  | Date: |  |
|  |
| [ ]  Verbally revoked this authorization on  |  |

**Notice Prohibiting Re-Disclosure of**

 **Substance Use Disorder Information**

**This notice must accompany an individual’s confidential alcohol or drug treatment records**

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| This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.  |