COUNTY OF LOS ANGELES
Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL

RELEASE OF INFORMATION – OUTSIDE SAPC SUD PROVIDER NETWORK

I. PATIENT INFORMATION		
Name (Last, First, and Middle):	Date of Birth:	Medi-Cal # or My Health LA #:
Address:		Phone Number:

II. ENTITIES WHO MAY SHARE HEALTH INFORMATION

I authorize the following entities to share my protected health information with each other for the purpose of coordinating my care, substance use disorder (SUD) treatment, non-medical services, and/or benefits acquisition.

Entity/entities <u>disclosing</u> information:

- _____
- _____
- _____

Entity/entities <u>receiving</u> information:

- _____
- _____
- _____

III. SCOPE OF DISCLOSURE

I permit the entities listed in Section II to share the protected health information specified below. Disclosure shall be limited to the following information:

- ☐ <u>ALL</u> information listed here in Section III
- ☐ Assessment information
- ☐ Case management/care coordination
- ☐ Treatment plans
- ☐ Progress notes
- ☐ Health records (primary care, sexual and reproductive health, etc.)
- ☐ Drug test results
- ☐ Laboratory test results
- ☐ Medications
- ☐ HIV/AIDS test information
- ☐ Discharge plans / summaries
- ☐ Mental health records
- ☐ Other (specify): _____

IV. EXPIRATION OF AUTHORIZATION

This Authorization will automatically expire on ____/____/____, or one year from date of execution of this Release, whichever is later.

V. OTHER IMPORTANT INFORMATION

By signing this Authorization, I understand that:

- My alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.
- This Authorization is voluntary and I do not need to sign this Authorization in order to receive treatment, enroll in services, or for payment for my health care.
- I have a right to receive a copy of this Authorization. A copy of this Authorization is as valid as the original.
- If information related to alcohol, drug or HIV/AIDS treatment is shared, that information cannot be re-disclosed except with another Authorization.
- I have the right to revoke this Authorization at any time in writing unless the entity disclosing my health information already shared my information before receiving my revocation. I may use the Revocation of Authorization at the bottom of this form to terminate this Authorization and may mail or deliver the revocation to the Substance Abuse Prevention and Control (SAPC; see mailing address below) or my substance use treatment provider.

Once my Revocation of Authorization is received, SAPC and/or my provider will cancel the Authorization and notify all involved parties of its cancellation.

VI. SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

I have read and understand the content of this Authorization. I am signing the Authorization voluntarily and understand that I have the right to refuse to sign this document. My signature authorizes the disclosure of the health information as described in Section III of this Authorization.

Name and Signature of Patient or Patient's Legal Representative:

_____ _____ _____/_____/_____

Print Name Signature Month Day Year

If signed by Patient's Legal Representative, state relationship and authority to do so:

_____

Witness: Name and Signature of Providers or Agency/Clinic Representative:

_____ _____ _____/_____/_____

Print Name and Title Signature Month Day Year

_____

Provider Address

VII. REVOCATION OF AUTHORIZATION

☐ I wish to revoke my authorization.

*Please send Revocation of Authorization to your health provider or SAPC at:
Substance Abuse Prevention and Control
1000 South Fremont Ave., Bldg. A-9 East, 3rd Floor
Alhambra, CA 91803

Name and Signature of Patient or Patient's Legal Representative:

_____	_____	_____/_____/_____
Print Name and Title	Signature	Month Day Year

If signed by Patient's Legal Representative, state relationship and authority to do so:

_____

VIII. PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to involved providers with the consent of such client. This information has been disclosed to involved providers from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit involved providers from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.