# Monterey County Behavioral Health

## Authorization for Use, Exchange, and/or Disclosure of Confidential Behavioral Health Information for Multi-Disciplinary Teams

Completion of this document authorizes the use or release of confidential behavioral health information about you (or your child). It is important that you complete this Authorization if you wish to authorize Monterey County Behavioral Health to use, disclose, or exchange confidential health information about you.

**Person in care's name** ____________________**Date of Birth**______________

I hereby authorize:

- ☐ Monterey County Behavioral Health, Mental Health Division
- ☐ Monterey County Behavioral Health, Substance Use Disorder (SUD) Division
  - The specific name(s) or general designations of the part 2 program(s), entity(ies), or individual(s) permitted to disclose the information identified within this authorization: ___________________________________________
    _________________________________________________________________
    _________________________________________________________________
- ☐ Monterey County Department of Probation
- ☐ Monterey County Department of Social Services
- ☐ My child's school Individualized Education Plan Team
- ☐ Named Monterey County MDT:______________________________
- ☐ Other: __________________________________________
- ☐ Other: __________________________________________

to use, disclose or exchange with each other confidential information about me for the following purpose(s):

- ☐ To evaluate my (my child's) need for behavioral or other health services;
- ☐ To provide and coordinate the services that are provided to me (my child) by the named Monterey County Multi-Disciplinary Team;
- ☐ To evaluate my (my child's) participation and progress in the named Monterey County Multi-Disciplinary Program
- ☐ Other :__________________________________________

I specifically authorize the use, exchange, or disclosure of the following health information pertaining to my (my child's) medical history, mental or physical condition, assessment, and treatment received, <u>including</u>:

☐ (a) Mental health information______ (Person in care's initials)
☐ (b) HIV test results______ (Person in care's initials)
☐ (c) The following substance use disorder information______ (Person in care's initials)
☐ (d) Physical Health Treatment Information ______ (Person in care's initials)
(Please explicitly identify the amount and any kind of substance use disorder in for which you are authorizing disclosure.)
_______________________________________________________________________
______________________________________________________________

This authorization expires:

☐ 90 days after my (my child's) treatment ends or when there is no longer any need for disclosure of the information by the named individuals or entities on this form, whichever is sooner.

**OR**

☐on (insert date or event):______________________

I may refuse to sign this Authorization. My refusal may affect my (my child's) ability to receive services from Monterey County Behavioral Health and multi-disciplinary program(s) Monterey County Behavioral Health participates in but will not affect my (my child's) ability to receive individual services provided by other County healthcare programs for which I (my child) may qualify.

I may inspect or obtain a copy of the health information that is the subject of this authorization.

I may revoke this authorization at any time either in writing or by verbally informing a Monterey County Behavioral Health service provider named on this form, or by notifying the named multi-disciplinary program. My revocation will take effect upon receipt, except to the extent others have acted in reliance on this Authorization.

I have a right to receive a copy of this authorization.

Information used, exchanged and disclosed pursuant to this authorization will not be redisclosed by any user or recipient except as required or permitted by law.

**Date:** ____________ **Time:** _________

**Signature:** ___________________________________________
(Name of person in care/representative)

If signed by someone other than the patient, please indicate relationship:

______________________________________________________