MONTEREY COUNTY BEHAVIORAL HEALTH
Authorization for Disclosure of Confidential Health Information – Multiple Enrollments
Opioid Treatment Programs

In accordance with 42 CFR §2.34, this authorization form allows Part 2 Programs to disclose patient records to a central registry or to any withdrawal management or maintenance treatment program not more than 200 miles away for the purpose of preventing the multiple enrollment of a patient. **DO NOT USE FOR OTHER PURPOSES.**

Note: A Part 2 Program may make disclosures pursuant to this authorization only if the disclosure is made when:

1. The patient is accepted for treatment;
2. The type or dosage of the drug is changed; or
3. The treatment is interrupted, resumed or terminated.

Completion of this document expressly authorizes the disclosure of confidential health information about you.

1. Patient's name (print): _____

   Patient's date of birth: _____

2. The specific name(s) or general designations of the Part 2 Program, entity(ies), or individual(s) permitted to disclose the information identified in this authorization:

   _____

   _____

3. The following health information may be disclosed:

   ☐ Patient identifying information ***(Patient's initials_____)***

   ☐ Type and dosage of the drug administered by the part 2 program ***(Patient's initials_____)***

   ☐ Dates relevant to the patient's treatment at the part 2 program ***(Patient's initials_____)***

4. I understand that the information identified in this authorization will be disclosed to the following named central registry(ies) and withdrawal management or maintenance treatment program(s):[1]

   □ Community Human Services- Off Main Clinic, 1083 S. Main St., Salinas, CA 93901 (831) 424-5838-fax
   □ Valley Health Associates- 338 Monterey Street, Salinas, CA 93901 (831) 424-9717-fax
   □ Janus of Santa Cruz- 200 7th Ave., Ste. 150, Santa Cruz, CA 95062 (831) 462-4970-fax
   □ Janus South County- 284 Pennsylvania Dr., Ste. 2, Watsonville, CA 95016 (831) 319-4204-fax
   □ South County Clinic – County of Santa Clara, 90 Highland, San Martin, CA 95046 (408) 683-0697
   □ Other:

   _____

   _____

   _____

   □ The information identified in this authorization may also be disclosed to any withdrawal management or maintenance treatment program established within 200 miles that is not named above. ***(Patient's initials_____)***

5. The information identified in this authorization will be disclosed for the purpose of limiting multiple enrollments in withdrawal management or maintenance treatment programs.

6. I hereby confirm my understanding I may **revoke** this authorization at any time, except to the extent that the Part 2 Program or other lawful holder has already acted in reliance on it. ***(Patient's initials_____)***

   I should submit my revocation in writing to the following address:
   □ Community Human Services- Off Main Clinic, 1083 S. Main St., Salinas, CA 93901
   □ Valley Health Associates- 338 Monterey Street, Salinas, CA 93901

[1] Part 2 programs acting pursuant to this authorization must list the name and address of each central registry, and each known withdrawal management or maintenance treatment program to which a disclosure will be made, and may only make disclosures to those withdrawal management or maintenance treatment programs established within 200 miles.

7. Patient's Rights and Warnings:
    - I may refuse to sign this authorization. My refusal could affect my ability to obtain services under this specific program, but efforts will be made to offer services under other programs.
    - I may inspect or obtain a copy of the health information of which I am authorizing disclosure.
    - I have a right to receive a copy of this authorization and will be offered a copy.
    - 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 (HIPAA)).
    - Substance use disorder information may not be re-disclosed unless another authorization for such disclosure is obtained from me, or unless such disclosure is specifically required or permitted by law.

Patient's signature: _____

Date:_____ Time:_____ am/pm

Printed name: _____

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

☐ parent/legal guardian of minor ☐ conservator

☐ other:_____