COUNTY OF MONTEREY
HEALTH DEPARTMENT
Elsa Jimenez, Director of Health

Administration
Behavioral Health
Clinic Services
Emergency Medical Services
Environmental Health/Animal Services
Public Health
Public Administrator/Public Guardian

Nationally Accredited for Providing Quality Health Services

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the use, disclosure, and exchange of health information about you. Failure to provide all information requested may invalidate this authorization.

Name of participant: _____

USE, DISCLOSURE AND EXCHANGE OF CONFIDENTIAL INFORMATION

I hereby authorize the named individuals and/or named entities listed on page 2 of this Authorization Form to use, disclose, and exchange the following health information about me:

☐ **A.** All health information pertaining to my medical history, mental or physical condition and treatment received;

OR

☐ **B.** Only the following records or types of health information (including any dates):

_____

_____

AND

☐ **I specifically authorize release of the following information** (check as appropriate):

- ☐ *Mental health treatment information_____(initial)
- ☐ HIV test results_____(initial)
- ☐ Substance use disorder (SUD) treatment information_____(initial)

  Substance use disorder information subject to this authorization must be explicitly described:_____

  _____

* A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as outlined in the federal regulations implementing the Health Insurance Portability and Accountability Act.

NAMED INDIVIDUALS AND ENTITIES THAT MAY USE, DISCLOSE AND EXCHANGE CONFIDENTIAL HEALTH INFORMATION ABOUT ME:

☐ **1. Members of the Monterey County Prop 47 Grant Service Team including:**

- ☐ Sun Street Centers (SSC)
- ☐ California Legal Rural Assistance (CRLA)
- ☐ Turning Point of Central California
- ☐ Motivating Individuals Leadership for Public Advancement (MILPA)
- ☐ Housing Resource Centers (HRC)
- ☐ Public Defender's Office of Monterey County
- ☐ Monterey County Behavioral Health

☐ **2. Other named individual(s) or named entities** *(for example, Probation Officer Mary Smith; John Anderson, Attorney at Law; CPS Case Worker Alice Gardner; primary care provider Dr. Anderson; Natividad Hospital; MediCal*) :_____

_____

_____
(include person's name, agency and address)

☐ **3. Named Health Information Exchange (HIE) or Research Institution**_____

_____

<u>One of the following box(es) MUST also be checked and completed</u>:

☐ Named individual or named entity participant *(for example, Pastor Diane Clark; Community Hospital of the Monterey Peninsula)*:_____

_____

_____

☐ *General designation of an individual or entity participant(s) or class of participants with treating provider relationship *(for example: my behavioral health providers that participate in the Monterey County HIE)*: _____

_____

_____

*If a general designation is indicated, please confirm your understanding that upon your request and consistent with 42 CFR Part 2, you must be provided with a list of entities to which this information has been disclosed pursuant to this general designation. **(Client/Client representative initials)_____)**

PURPOSE

State the specific purpose(s) of requested use, disclosure, or exchange (limited to that information necessary to carry out the stated purpose):

☐ **Enrollment and case management services by Prop 47 Grant Service Team**, including evaluation, assessment, referral and treatment by various health care providers and others, including staff from social services and housing services, to ensure that I will be able to successfully benefit from all services that might be available to me.

Limitations, if any:_____

_____

OR:

☐ Client request

OR:

☐ Other:_____

EXPIRATION

Unless revoked sooner, this authorization expires on: _____

_____

(date, event or condition)

MY RIGHTS

- 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 that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, either verbally or in writing; if I do so in writing I understand that I may submit my revocation to the following address: Monterey County Behavioral Health, Prop 47 Grant Director, 1270 Natividad Road, Salinas, Ca 93906. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- 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 law and may no longer be protected by federal confidentiality law (HIPAA). For example, if I authorize the disclosure of information to a family member.
- Generally, substance use disorder (SUD) information may not be re-disclosed to any other person or entity or in any manner not covered in this specific authorization, unless another authorization for such disclosure is obtained from me, or unless such disclosure is specifically required or permitted by law.

SIGNATURE

_____ Date:_____Time:_____
(signature of client/client representative) am/pm

Printed name: _____

If signed by a person other than the client, indicate relationship:
☐ conservator
☐ other:_____