Monterey County Behavioral Health

GENERAL-Authorization for Use, Exchange, and/or Disclosure of Confidential Behavioral Health Information

Completion of this document authorizes the disclosure of confidential health information about you. Please complete this authorization if you wish to expressly authorize Monterey County Behavioral Health or its contractors to disclose confidential health information about you.

1. **(a) Person in care's name (print)**: _____

   (b) Person in care's date of birth: _____

2. **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**:

   _____

   _____

3. **The following health information may be disclosed.** (Please check boxes below or explicitly identify the amount and kind of health information for which you are authorizing disclosure.)

   ☐ (a) Mental health treatment information[1] _____ (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 kind of substance use disorder information for which you are authorizing disclosure.)

   _____

   _____

[1] 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 (HIPAA).

4. The information identified within this authorization may be disclosed to the following **named individual(s) or entities:**

_____

_____

5. The information identified in this authorization may be disclosed for the following **purpose**(s) (please explicitly identify the purpose(s) for which you are authorizing disclosure):

_____

_____

6. I hereby confirm my understanding that this authorization is subject to revocation at any time, except to the extent that an entity or individual permitted to make the disclosure pursuant to this authorization 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. _____ (**Person in care's initials**)

7. This authorization will expire, if not revoked before, 90-days after my treatment ends or upon the following date, event or condition:

_____

_____

8. Patient's Rights and Warnings:

   (a) 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.

   (b) I may inspect or obtain a copy of the health information of which I am authorizing the disclosure.

   (c) I may revoke this authorization at any time, either verbally or in writing. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

   (d) I have a right to receive a copy of this authorization and will be offered a copy.

   (e) 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. HIPAA).

(f) 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.

Person in care's signature: _____

When required for a person in care who is incompetent or deceased, the signature of an individual authorized to sign under 42 CFR §2.15: _____

If signed by a person other than the person in care, pursuant to 42 CFR §2.15, identify the relationship of the person authorized to sign: _____

Date: _____

Was this form translated for individual in a language other than English?
If so, indicate the language _____.

Was copy of this Authorization accepted by client or representative □ **Yes** □ **No**
Indicate reason not accepted_____