Monterey County Behavioral Health
Authorization for Disclosure of Confidential Health Information *WITHIN*
Monterey County Behavioral Health System

Completion of this document expressly authorizes the disclosure of 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:** Monterey County Behavioral Health, SUD Programs: Community Human Services, Valley Health Associates, Door to Hope, Sun Street Centers

   _____

3. **The following health information may be disclosed.** (Please check boxes below or explicitly identify the amount and kind of substance use disorder 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):

   _____

   Current and historical information; all treatment information about me, including, intake, assessment, treatment plan, progress notes, referrals & lab work; _____ **(Person in care's initials)**

[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 in this authorization may be disclosed to the following **named individual(s) or entities:** Monterey County Behavioral Health, SUD Programs: Community Human Services, Valley Health Associates, Door to Hope, Sun Street Centers

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):
Assessment, diagnosis, treatment, care coordination, discharge planning, and referral;

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. 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**_____**)**

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.

7. Unless revoked sooner, this authorization will expire 365 days after my treatment ends or on the following date, event, or condition:_____

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.
- Some 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 specifically required or permitted by the law, or permitted by this authorization.

Person in care's signature: _____

Date:_____ Time:_____AM/PM

Printed name: _____

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

□ parent/legal guardian of minor □ conservator

□ other:_____

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_____