San Bernardino County Department of Behavioral Health
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
Mental Health and Substance Use Disorder Treatment

Client Name: _____ Date of Birth: / / *(Month/Date/Year)*

Client Address: _____ Last 4 digits SSN: XXX / XX / _____

_____ Client Phone: ( )

Completion of this document authorizes the release and use of your health information. Failure to provide all information requested may invalidate this Authorization.

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize _____ **to release to:**
(Facility Name/Provider/Other)

Name (To Whom): _____
(Individual or Treating Provider or Third Party Payer or Non-treating Provider)

To:
(*SUD only*) _____
(Only completed if Non-treating Provider Entity/Non Third Party Payer Entity)

☐ Select if "*general designation*" if you are requesting an intermediary facilitate health information exchange, which allows a non-treating entity to obtain PHI and then disclose to multiple treating provider entities listed in the "To" section. A list of disclosures made by the non-treating entity through general designation must be maintained for any future disclosures by the non-treating entity.

Address: _____

City, State Zip: _____

Phone Number: ( ) _____ Fax Number: ( ) _____

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

☐ **Mental Health** treatment information _____ *(client or legal representative's initials)*
☐ **Substance Use Disorder (SUD)** treatment information _____ *(client/legal representative's initials)*

b. I authorize release of:

☐ All my health information pertaining to my medical history, mental health condition, SUD treatment (must be accompanied with one other identifier); from_____ to_____ **OR**
☐ Only the following records or types of health information; from_____ to_____
☐ Assessment ☐ Client Plan ☐ Summary Letter ☐ Attendance ☐ Treatment Notes
☐ Discharge Summary ☐ Diagnosis ☐ Medication ☐ Other _____

c. If releasing **SUD** treatment information please select from the following recipient options:

☐ Individual *(name of intended recipient)*
☐ Treating Provider Entity *(name of entity which has a "treating provider relationship")*
☐ Third Party Payer *(name of entity with no treating provider relationship, but is a third party payer)*
☐ Non-Treating Provider Entity *(name of entity with no treating provider relationship and not a third party payer)*

Note: If "Non-Treating Provider Entity" is selected, <u>one</u> of the following additional identifiers must also be included on the "To" line above: 1) name of individual participant(s); 2) name of treating provider participants or entities with a treating provider relationship ***if*** general designation is selected and the non-treating entity in the "To Whom" section will be storing PHI to facilitate an exchange amongst treating providers after the initial disclosure.

PURPOSE

Purpose of requested use or disclosure: ☐ client request; **OR** ☐ other *(please list purpose)*:

Limitations, if any:

EXPIRATION (MENTAL HEALTH)

This Authorization expires *[insert exact date]*: _____

Note: California law requires you enter an exact date; otherwise, DBH cannot process this Authorization.

REVOCATION (MENTAL HEALTH)

I understand that I may cancel this Authorization at any time, but I must do so in writing by submitting my request for revocation to the health care facility that I authorized to release my health information. If I revoke this Authorization, I must submit to the following address: _____.

(Insert the address of the DBH Clinic authorized to disclose or use the client's health information)

My cancellation of this Authorization will take effect upon receipt by DBH and no further information will be released based on the cancellation. I understand that DBH may not be able to retrieve any information that has already been released prior to the revocation.

EXPIRATION (SUD)

Unless I revoke my consent earlier, this consent will expire automatically as follows:

_____.

(Describe date, event, or condition upon which consent will expire, which must not be longer than reasonably necessary to serve the purpose of this consent)

REVOCATION (SUD)

I understand that I may cancel this Authorization at any time, but I must do so in writing by submitting my request for revocation to the health care facility that I authorized to release my health information. If I revoke this Authorization, I must submit to the following address:

_____.

(Insert the address of the DBH Clinic authorized to disclose or use the client's health information)

My cancellation of this Authorization will take effect upon receipt by DBH and no further information will be released based on the cancellation. I understand that DBH may not be able to retrieve any information that has already been released prior to the revocation.

San Bernardino County Department of Behavioral Health
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
Mental Health and Substance Use Disorder Treatment

MY RIGHTS (MENTAL HEALTH)

- I may refuse to sign this Authorization. My refusal to sign will not affect my ability to get treatment, payment or eligibility for benefits.
- I have a right to receive a copy of this Authorization.
- To the extent permitted by law, I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I understand the health information I authorized for release could be re-disclosed by the person/entity I designated to receive the information. I understand DBH cannot prevent my information previously released by this Authorization from being re-released by whoever received it.
- I understand in some cases California law does not prohibit the re-release of my information and my information may no longer by protected by federal confidentiality law (HIPAA). However, I understand California law prohibits the person or entity receiving my health information from making additional disclosures unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

MY RIGHTS (SUD)

- I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA), 45 C.F.R. Sections 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.
- I understand that I might be denied service if I refuse to consent to a disclosure for purpose of treatment, payment, or health care operations, if permitted by state law.
- I will not be denied services if I refuse to consent to a disclosure for other purposes.
- I understand that if the general designation option is used on this Authorization I must be provided, upon my request, with a list of entities to which my information has been disclosed pursuant to the general designation (the list of disclosures).
- I have been provided a copy of this form.
- If a "general designation" is selected to allow all my treating providers to receive specified information, I understand I have the right to obtain a list of disclosures if a request is made in writing (within two years of disclosure) 30 days from the date the written request is received; list of disclosure shall contain name of entity disclosure was made to, date of disclosure, and brief description of identifying information released.

SIGNATURE

Date: _____ Time: _____ ☐ am ☐ pm

Signature: _____

(DBH client shall sign, including minor age 12 and up, if having legal and mental capacity)

Signature: _____

(legal representative of client or parent/guardian for minors not having capacity to consent)

If signed by someone other than the client, state your name and legal relationship to the client:

_____

(Name and relation to client)

San Bernardino County Department of Behavioral Health
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
Mental Health and Substance Use Disorder Treatment

NOTICE PROHIBITING RE-DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION

(This form must be given to every individual and/or entity provided with SUD treatment information)

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information in NOT sufficient for this purpose (see §2.31), The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided in §2.12 (c)(5) and 2.65.

LANGUAGE TAGLINES

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call *[1-888-743-1478]* (TTY: *[711]*).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al *[1-888-743-1478]* (TTY: *[711]*).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số *[1-888-743-1478]* (TTY: *[711]*).

Tagalog (Tagalog– Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa *[1-888-743-1478]* (TTY: *[711]*).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. *[1-888-743-1478]* (TTY: *[711]*)번으로 전화해 주십시오.

繁體中文**(Chinese)**
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 *[1-888-743-1478]* (TTY: *[711]*)。

Հայերեն **(Armenian)**
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք *[1-888-743-1478]* (TTY (հեռատիպ)՝ *[711]*):

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните *[1-888-743-1478]* (телетайп: *[711]*).

فارسی **(Farsi)**
توجه: اگر به زبان فارسی گفتگو می‌شود، تسهیلات زبانی تی رایگان به صورت شما ارائه می‌شود. با *[1-888-743-1478]* (TTY: *[711]*) تماس بگیرید

日本語 **(Japanese)**
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。*[1-888-743-1478]* (TTY: *[711]*) まで、お電話にてご連絡ください。

Hmoob (Hmong) LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau *[1-888-743-1478]* (TTY: *[711]*).

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਧਿਓ: ਜੇ ਤੁਸ ੀਂ ਪੰਜਾਬ ਬੋਲਿ ਹੋ, ਤਾ ੀਂ ਭਾਸ਼ਾ ਧ ਿੱਚ ਸਹਾਇਤਾ ਸੇ ਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਿ ਹੈ। *[1-888-743-1478]* (TTY: *[711]*) 'ਤੇ ਕਾਲ ਕਰੋ।

الـ عربـ ية (Arabic)
بـ رقـ م اتـ صل .بـ الـ مجان لـ كـ تـ توافـ ر الـ لـغويـ ة الـ مـ ساعدة خدمات فـ إن الـ لـغة، اذكـ ر تـ تحدث كـ نت إذا :مـ لحوظة
[1-888-743-1478]
(م رقـ ف هلتـ صم الـ بـ كم الـ والـ :*[711]* .)

हिंदी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। *[1-888-743-1478]* (TTY: *[711]*) पर कॉल करें।

ภาษาไทย **(Thai)**
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร *[1-888-743-1478]* (TTY: *[711]*).

ខ្មែរ (Cambodian)
ប្រយ័ត្ន៖ រ ើសិនជាអ្នកនិយាយ ភាសាខ្ម , រសវាជំនួយមននកភាសា រោយមិនគិត្ថ្លៃ
គឺអាចមានសំរា ់ ំរ ើអ្នក។ ចូ ទូ ស័ព្ទ *[1-888-743-1478]* (TTY: *[711]*)។

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ,
ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ *[1-888-743-1478]* (TTY: *[711]*).