AUTHORIZATION FOR USE, EXCHANGE, AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
Substance Use Disorder

Completion of this document authorizes the disclosure of confidential health information about you. Complete this authorization if you authorize **Fresno County Behavioral Health or its contracted Substance Use Disorder treatment providers** to disclose confidential health information about you.

Name: _____ Date of Birth: _____
Last 4 Digits of Social Security Number: _____ Record #: _____

Name or general designation of individual or entity making the disclosure: _____

_____

To disclose the following type and amount of information as follows:

☐ Initial Screening ☐ Referrals ☐ Diagnosis ☐ Lab Report
☐ Progress Report ☐ History & Physical ☐ Medication Record ☐ Progress Notes
☐ Attendance ☐ Assessment ☐ Treatment Plan ☐ Immunization Record
☐ Verbal or Written Exchange of Treatment Information to/from of individual or entity making the disclosure to Named recipient(s)
☐ Other: _____

The information identified within this authorization may be disclosed to the following:

(A) Recipient entity(ies) with a treating provider relationship. *[Instruction: Include a name of the entity such as a hospital, a behavioral health organization, or an SUD treatment program.]*
Name of recipient entity(ies): _____

_____

_____

(B) Recipient individual(s). *[Instruction: Include a full name of anyone such as a name of a doctor, a lawyer, a court personnel, a public health agency staff, or a social worker.]*
Name of recipient individual(s): _____

_____

_____

(C) Recipient third-party payer(s). *[Instruction: Include a name of the entity that is the insurer.]*
Name of recipient third-party entity: _____

_____

_____

The information identified in this authorization may be disclosed for the following purpose(s):

☐ Coordination/Continuity of Care ☐ Referrals ☐ Treatment
☐ Legal ☐ Insurance ☐ Social Security Appeal
☐ Disability Claim ☐ Eligibility for Public Assistance

Rights and Warnings:

I understand that I have the following rights and warnings with respect to this Authorization:

(1) I may refuse to sign this authorization. I understand that I might be denied services if I refuse to consent to a disclosure for purposes 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.

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

(3) 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.

(4) 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. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

(5) I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

This authorization will expire, if not revoked before, on date _____ or upon the following event or condition: _____
If I do not specify an expiration date or event, this authorization will expire in one year.

I have been provided a copy of this form on: _____
Client's signature: _____
Client's printed name: _____ Telephone number: _____
Client's address: _____

When required for a patient who is incompetent or deceased under 42 CFR §2.15:
Signature of an individual authorized: _____
Describe authority to sign on behalf of client/Relationship: _____

Revocation:

☐ I revoke this authorization Signature: _____ Date: _____
☐ Client verbally revoked this authorization on _____

Notice Prohibiting Re-Disclosure of Substance Use Disorder Information

This notice must accompany a client's confidential alcohol or drug treatment records

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 is 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 at §§ 2.12(c)(5) and 2.65.