AUTHORIZATION FOR USE, EXCHANGE, AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Fresno County Behavioral Health and Fresno County Behavioral Health Substance Use Disorder Treatment Provider Network/Mental Health Diversion Court

Name: ______________________ Date of Birth: ______________
Last 4 Digits of Social Security Number: __________ Record #: ______________

Name or general designation of individual or entity making the disclosure (these individuals/entities are also authorized to receive and use the information listed below):
(1) Fresno County Department of Behavioral Health, **(2)** Wellpath **(3)** K&L Clinical Forensic Practice **(4)** Turning Point of Central California, Inc. – Diversion Program, **(5)** Turning Point of Central California, Inc. – First Street Center Program

To disclose the following ☒ substance abuse, ☐ medical, and ☒ mental health 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 entity (ies) or individual (s)

☒ Other: _Toxicology test results_______________________________

Dates of information from: Birth to: Final disposition of case in Mental Health Diversion Court

Name of entity (es) or individual (s) authorized to receive and use the information:
(1) Fresno County Public Defender's Office, **(2)** Superior Courts of Fresno County, **(3)** Fresno County District Attorney's Office, **(4)** Fresno County Probation, **(5)** Fitzgerald, Alvarez & Ciummo **(6)** Alternative Defense Office **(7)** My Non-listed Defense Counsel **(add first and last name or law office)** ________________________________

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	☒ Other Recommendations	

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.

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

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

(4) 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 of 1996 (HIPAA)).

(5) 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.

(6) I understand that I may revoke this authorization at any time verbally or in writing to the following address: 4441 E. Kings Canyon, Fresno, CA 93702 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).

This authorization will expire, if not revoked before, on date N/A ____________ or upon the following event or condition: Final disposition of case in Mental Health Diversion Court ____________
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: ____________________

Signature: ____________________ Date: ____________

Name: ____________________ Telephone number: ____________

Address: ____________________

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

☐ Parent/legal guardian of minor ☐ Conservator ☐ Other: ____________

Revocation:

☐ I revoke this authorization Signature: ____________ Date: ____________

☐ Verbally revoked this authorization on ____________________

Notice Prohibiting Re-Disclosure of Substance Use Disorder Information

This notice <u>must</u> accompany an individual'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.