County of Butte - Authorization for Use or Disclosure of Health Information

CLIENT INFORMATION		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS	CITY/STATE/ZIP CODE:	DATE OF BIRTH:
CLIENT'S PHONE NUMBER	CLIENT FILE/CASE NUMBER	

AUTHORIZATION DETAILS

Records Coming From **(Disclosed by):** Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to make use of and/or disclose the information described in this form.

Butte County Department of Behavioral Health
Butte County District Attorney's Office
Butte County Public Defender's Office
Butte County Superior Court
Butte County Department of Employment and Social Services

Records Going To **(Received by)**: Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to receive the information described in this form.

Butte County Department of Behavioral Health
Butte County District Attorney's Office
Butte County Public Defender's Office
Butte County Superior Court
Butte County Department of Employment and Social Services

PURPOSE OF DISCLOSURE OF PHI

☐ Treatment and treatment-related activities (to assess, coordinate, provide, or refer to others, for treatment)
☐ Case Management /Oversight (to other agencies and providers for services other than treatment)
☐ Payment, billing, insurance claim, eligibility for public/private benefits
☐ At the request of the individual/client ☐ At the request of an authorized representative
☐ OTHER: _____

SERVICE DATES

The information to be used or disclosed includes only those items checked above, with respect to services provided on or around: _____ (insert dates of service). **NOTE**: If this section is left blank, the treatment dates covered by this authorization are from the most recent date of service (or course of treatment) and claims resolution.

EXPIRATION OF AUTHORIZATION

THIS AUTHORIZATION SHALL BECOME VALID IMMEDIATELY AND SHALL REMAIN IN EFFECT FOR THE FOLLOWING PERIOD: ***(The Client/Patient MUST INITIAL one of the following for the authorization to become valid.)***

_____ This authorization expires one year from the signature date below.
_____ This authorization expires as specified: Upon termination of Mental Health Diversion
_____ This authorization expires once information is disclosed. This is a one-time authorization.

County of Butte-Behavioral Health Authorization for Use or Disclosure of Protected Health Information (PHI)	**Client Name:** _____ **Client Number:** _____

TYPE OF INFORMATION TO BE USED OR DISCLOSED

I understand that this authorization extends to all or any part of the records/information designated below, which may include treatment for mental illness and/or alcohol/drug abuse. The information to be used or disclosed includes: ***(The client MUST INITIAL items being requested)***

(_____) Assessment/History (_____) Treatment Records
(_____) Medication Records (_____) Lab Reports
(_____) Inpatient Records (_____) Intake/Admission Summary (_____) Medical Finding
(_____) Progress Notes: (specify) _____
(_____) Billing Records (____) Financial Records:(specify)_____
(_____) Public Social Services Records (Welfare and Related Social Programs Information)
(_____) Discharge Summary
(_____) OTHER (please specify): Diagnosis, Treatment Plan, and reports regarding progress in Treatment

I UNDERSTAND THAT THE INFORMATION TO BE DISCLOSED WILL INCLUDE: *(Client MUST INITIAL)*

(_____) Alcohol/Drug Records OR (_____) Do Not Disclose
(_____) Attendance Only OR (_____) Do Not Disclose
(_____) Mental Health Records OR (_____) Do Not Disclose
(_____) HIV Test Results OR (_____) Do Not Disclose

This authorization is limited to only that information that I have requested above to be used or disclosed to the persons/facilities named herein. I hereby release the County of Butte from all legal responsibilities or liability that may arise from the use or disclosure of information in reliance on this authorization.

NOTICE TO RECIPIENT OF PHI

Please note Federal Confidentiality Rules (42 CFR Part 2) and California Law prohibit further disclosure of medical and/or mental health records, unless further use or disclosure is expressly permitted by obtaining a written authorization for disclosure of information from the person to whom it pertains. A general authorization for the use or disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

CLIENT RIGHTS & RESPONSIBILITIES

1. **Re-Disclosure under HIPAA:** I understand that information used or disclosed in accordance with this authorization may no longer be protected by the Health Insurance Portability & Accountability Act of 1996 (HIPAA), and could be used or re-disclosed by the receiving party. However, as noted above, federal and state regulations governing the confidentiality of alcohol and drug abuse patient records will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from re-disclosure.
2. **Revocation:** I have the right to make a written request to stop the use or disclosure of information at any time although I understand that I cannot do anything about information already used or disclosed under this authorization.

County of Butte-Behavioral Health Authorization for Use or Disclosure of Protected Health Information (PHI)	**Client Name:** _____ **Client Number:** _____

3. **Refusal to sign:** I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits except as may be permitted by law.
4. **Copy:** I understand that I will receive a copy of this authorization free of charge. However, for requests for other file copies, a fee may apply.
5. **Minors**: I understand that minors 12 years of age and older may be required to sign the authorization along with their parent/guardian.

SIGNATURE

Client Signature: _____ Today's Date: _____

If Applicable:

Parent/Guardian/Authorized Representative Signature: _____
Today's Date: _____
Print Name: _____ Telephone Number: _____
Complete Address: _____
Street Address *City* *State* *Zip Code*
Relationship to Client _____

COPY: ( ) Given to client at time of signature; ( ) Given to client on _____ ( ) Mailed to client on _____ ( ) Copy Refused by Client _____ (initial and date) Filed on _____.

REVOCATION OF AUTHORIZATION

As of this date, _____, I hereby revoke this authorization.

_____ _____
Name of Client Signature of Client Revoking Authorization

If Applicable:

_____ _____
Name of Parent/Guardian Signature of Parent/Guardian Revoking Authorization

STAFF VERIFICATION

(FOR INTERNAL USE ONLY)

- ☐ I have verified the client's signature against the medical record.
- ☐ I have relied on the following identification: _____
- ☐ Known to County Staff by: ☐ Prior verification ☐ Other: specify_____
- ☐ I have received _____ as documentation that verifies the representative's relationship with the client and the authority to request/receive health information on behalf of the client.

Staff Signature: _____ Date: _____
Print Staff Name: _____

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