MODOC COUNTY Behavioral Health

Substance Use Disorder / Mental Health

Release of Information - ROI

441 N Main St. Alturas, Ca 96101 Phone (530)233-6312 Fax (530)233-6339 42 CFR Part 2 Compliance

Completion of this document expressly authorizes the disclosure of confidential health information about you.

1. **Patient's name (print): ____**

   Patient's date of birth: _________________ Client ID #___________

2. **The specific name(s) or general designations of the Part 2 program, entity, or individual(s) permitted to disclose the information identified in this authorization**:

   Modoc County Behavioral Health

3. **The following health information may be disclosed/receive**. (Please initial **ONLY** the information you wish to disclose/ receive)

Mental health treatment information[1]

_____ Compliance with treatment, including attendance, progress, violations, participation or disciplinary actions

_____ Scheduling and logistics

_____ Assessment/Diagnosis

_____ Treatment verification

_____ Discharge summary

_____ Entire Behavioral Health Record

_____ Legal information

_____ Medication

_____ Physical Health Treatment Information

☐ **Substance use disorder information** (the SUD information you wish to disclose must be explicitly described):

____ ***(patient'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).

(Form Effective Date: August 14, 2020)

4. (i) The information identified in this authorization may be disclosed to the following **named individual(s) or named entity(ies)**:

____
____
____
____

(ii) The information identified in this authorization may be disclosed to the following **named entity that either facilitates the exchange of health information or is a research institution**:____
____
____

<u>PLUS</u> at least one of the following two choices with which the entity without a treating provider relationship may share this information:

☐ The following named **individual or entity participant(s):**________________

____

☐ A general designation of an **individual or entity participant(s) or class of participants** that must be limited to a participant(s) who has a treating provider relationship with the patient whose information is being disclosed:

____

Note: When using a general designation, the patient (or other individual authorized to sign instead of the patient), confirms their understanding that, upon their request and consistent with 42 CFR Part 2, they must be provided a list of entities to which their information has been disclosed pursuant to the general designation (see §2.13(d)). ***(Patient's initials____)***

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):
_____ Coordination of treatment services _____ Personal _____ Legal
_____(other)___________________________

6. I hereby confirm my understanding that 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). ***(Patient's initials____)***

   I should submit my revocation in WRITING to the following address: 441 N Main St. Alturas, Ca 96101 or VERBALLY to my clinician or front office staff.

7. Unless revoked sooner, this authorization will **expire** on the following date, event, or condition:____

8. 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)).

- NOTICE: 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.

Patient's signature: ____

Date:_______________________________ Time:__________am/pm

Printed name: ______________________________________

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

☐ parent/legal guardian of minor ☐ conservator

☐ other:________________________________

Witness:____________________________ Date:______________

(Form Effective Date: August 14, 2020)

---------------------------------For Office Use Only----------------------------------

REVOCATION SECTION

Staff initials:________

Date revoked: _______________________

(Form Effective Date: August 14, 2020)