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1400 Emeline Avenue,
Santa Cruz, CA 95060
Phone: (831) 454-4170
Fax: (831) 454-4663

COUNTY OF SANTA CRUZ
Behavioral Health Services
FOR CHILDREN & ADULTS

1430 Freedom Blvd. Ste F,
Watsonville, CA 95076
Phone: (831) 454-4170
Fax: (831) 454-4663

Client Legal Name:			Avatar No:
Nickname/Alias:	Date of Birth:		Phone:
Address:	City:	State:	Zip:

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AUTHORIZATION for the RELEASE/SHARE of CONFIDENTIAL INFORMATION

I, _____(PRINT NAME of LEGAL AUTHORIZOR) authorize **Behavioral Health Services** ☐ **MHP or** ☐ **SUDS** (*check appropriate box*) **Staff** to share (give and/or receive) the below identified information to: (AGENCY/ENTITY) authorized to receive my treatment information. [CARES Act *permits "organization/agency" for SUD disclosures.]*

Recipient Name: _____

Address: _____ Phone: _____

[**FOR Children's Mental Health (CBH) staff (minor ownership)**: *My signature below confirms that I have assessed this 12-17 year old minor and determined the minor* ☐ *does* ☐ *does not have the capacity to authorize the release of her/their/his protected health information.]* _____/_____ (CBH Staff Signature/Date)

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The purpose for the communication, disclosure and exchange of this information is:

☐ Facilitate treatment/payment/operational coordination ☐ Summarize treatment
☐ Other (Specify reason): _____
☐ Claims Assistance ☐ Quality of Care Review/Complaint ☐ Appointment Support/Scheduling Help

4

I permit staff to release/share the following sensitive information: [please check appropriate boxes]:

☐ All Mental Health Treatment Information: **FROM** _____ **TO** _____ [Optional: *Specify Unique Date Limit*]
☐ All Substance Use Disorder Treatment Information: **FROM** _____ **TO** _____ [**REQUIRED for SUD**: *Specify Unique Date Range Limits – 42 CFR section 2.31*]
☐ Only the following information (can specify any type and/or date range): _____
_____
_____
☐ Diagnosis ☐ Only treatment enrollment confirmation ☐ Psychiatry treatment, including medications
☐ HIV/AIDS Test Results (A separate authorization is required for each disclosure & **required signer initials)**: _____

5

DURATION: This authorization is valid until: _____ (Date or event) or one (1) year from the date this form is signed, whichever date is earlier.

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MY RIGHTS: (1) I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or eligibility for benefits.**(2)** I understand that this is a communication release.**3)** I understand if I authorize disclosure of my protected health information to someone who is not covered by confidentiality laws (such as a family friend) it is possible that my information may be re-disclosed by that person to someone else.**(4)** I may revoke this authorization at any time by submitting a written revocation to: Quality Improvement, 1400 Emeline Avenue, Santa Cruz, CA 95060 to activate the revocation effective date.**(5)** I have the right to a copy of this authorization form and was offered a copy.(*Initial:* ___)

7 Client Signature:	Date:

8

Parent/Legal Guardian Signature: _____ **Date:** _____
(If signed by someone other than the client, state your legal relationship to the client): _____
Behavioral Health Staff (Print/Sign): _____ **Date:** _____
Legal Guardian or Conservator must provide a copy of current legal appointment papers to receive information

Release of Information Form Instructions

1
- Please fill out client information in Box 1
- Behavioral Health Staff can help with the Avatar Number

2
- Client to enter name on the first line
- Client to mark the type of Behavioral Health Services provider who is **authorized to release or share** treatment information: Choose: "MHP" box for mental health treatment provider or "SUDS" box for substance use disorder treatment provider. Both boxes can not be selected.
- Recipient Name: Client to enter person's name or entity/organization and fill in address and phone number of entity who can **receive** treatment information.
    - If Client wants SUD staff to share information with MH staff, Enter "Behavioral Health Services"
- If Client receiving mental health services is a minor 12 years of age or older and wants to release information, then Children's Mental Health (CBH) staff box needs completion before form is valid.

3
- Check any box(s) that describes the reason for the exchange or disclosure of this information

4
- Check any box(s) that describes what type of information you are permitting staff to release or share.
- Note that for Mental Health treatment entering a "From" and "To" Date is **optional**
- Note that for Substance Use Disorder treatment information "From" and "To" date is **required**
- Note that for HIV / AIDS Test Results to be released you must initial the form and a separate authorization is required for each HIV / AIDS disclosure

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- Indicate how long the authorization is valid
- This release is valid beginning immediately when you sign the form
- You can indicate an end date that is any time up to one (1) calendar year (12 months) from the date you sign the form
- If no end date is entered, the release will expire 12 months from the date the form is signed

6
- Your RIGHTS – Please read!
- You have a right to have a copy of this authorization. Please initial that you have been offered a copy

7
- Sign and date the release of information

8
- If you are not the client, describe your relationship to the client and legal authority to sign the form
- You may be required to provide legal paperwork
- Behavioral Health staff may sign the form as a staff witness