Alameda County Behavioral Health Care Services (BHCS)
2000 Embarcadero Cove, Suite 400 Oakland, California 94606

AUTHORIZATION TO DISCLOSE MY INDIVIDUALLY IDENTIFIABLE SUD INFORMATION – BHCS SUD PROGRAMS

PATIENT INFORMATION

Last Name **First Name** **Middle Initial**

Date of Birth **Social Security No.** **Home Phone** **Work Phone** **Extension**

Street Address **City** **State** **Zip Code**

I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE SUBSTANCE USE DISORDER (SUD) INFORMATION BE RELEASED FROM:

- BHCS County Staff
- BHCS SUD Provider Network (collectively SPN)*
- Cal. Dept. of Health Care Services
- Medi-Cal, Medicaid, and/or Medicare
- The following insurance company or payer:

(☐) Check box and complete below to add a treatment provider outside BHCS/SPN network:

Non-SPN Treatment Provider **Phone Number** **Extension**

Street Address **City** **State** **Zip Code**

I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE SUD INFORMATION BE RELEASED TO AND USED BY:

- BHCS County Staff; • SPN*
- Cal. Dept. of Health Care Services
- Non- SPN Treatment Provider named above
- Medi-Cal, Medicaid, and/or Medicare
- The following insurance company or payer:

(☐) For Other, check box and complete below:

Name of Provider/Clinic/Hospital **Phone Number** **Extension**

Street Address **City** **State** **Zip Code**

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AUTHORIZATION TO DISCLOSE MY INDIVIDUALLY IDENTIFIABLE SUD INFORMATION – BHCS SUD PROGRAMS

I understand that my SUD treatment, diagnosis, and referral; payment; enrollment; case management; care coordination; medication management; and/or eligibility for benefits are conditioned on completing this authorization.

EXPIRATION:
This Authorization expires twelve (12) months from last date of SUD services by BHCS and/or SPN.

Disclosure Purpose	Amount and Kind
• Treatment, Diagnosis, and Referral • Payment • Case management, care coordination, and medication management • Eligibility, coverage, and coordination of public assistance, benefits, & services • Health care operations activities • Research, evaluation, audit	• Limited to that information which is necessary to carry out the Disclosure Purpose • I permit lawful holders to re-disclose my protected SUD information subject to this authorization and 42 CFR part 2 • Other: _____

Signature of Patient	Print/Type Name	Date

Signature of Parent or Guardian	Print/Type Name	(☐) Parent (☐) Guardian	Date

REVOCATION AND REQUEST: I understand that I have a right to revoke this authorization at any time unless action has been taken in response to or in reliance on this authorization. I understand to contact a BHCS Health Information representative in order to revoke the authorization granted to BHCS. I further understand that I should provide a separate revocation to any other person or entity that I have authorized to disclose, receive, or otherwise use my individually identifiably SUD information above in order to revoke the authorization granted to that person or entity.

* SPN includes past, current, and future network providers. A directory of current network providers participating in the SPN is available at http://www.acbhcs.org/SUD/docs/SUD_providers_dirctory.pdf. I understand that I have a right to request a list of entities to which my patient identifying information has been disclosed pursuant to a general designation under this authorization and applicable regulations. I further understand that such a request must be in writing and limited to disclosures made within the past two years.

PROHIBITION ON RE-DISCLOSURE OF PROTECTED SUD INFORMATION: 42 CFR part 2 prohibits unauthorized disclosure of these records.

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AUTHORIZATION TO DISCLOSE MY INDIVIDUALLY IDENTIFIABLE SUD INFORMATION – BHCS SUD PROGRAMS EMERGENCY CONTACT

PATIENT INFORMATION

Last Name	First Name	Middle Initial

Date of Birth	Social Security No.	Home Phone	Work Phone	Extension

Street Address	City	State	Zip Code

I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE SUBSTANCE USE DISORDER (SUD) INFORMATION BE RELEASED FROM:

- BHCS County Staff
- BHCS SUD Provider Network (collectively SPN)*

(☐) Check box and complete below to add a treatment provider outside BHCS/SPN network:

Non-SPN Treatment Provider	Phone Number	Extension

Street Address	City	State	Zip Code

I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE SUD INFORMATION BE RELEASED TO AND USED BY:

Name of Emergency Contact #1	Phone Number	Extension

Street Address	City	State	Zip Code

Name of Emergency Contact #2	Phone Number	Extension

Street Address	City	State	Zip Code

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AUTHORIZATION TO DISCLOSE MY INDIVIDUALLY IDENTIFIABLE SUD INFORMATION – BHCS SUD PROGRAMS EMERGENCY CONTACT

I understand that my SUD treatment, diagnosis, and referral; payment; enrollment; case management; care coordination; medication management; and/or eligibility for benefits are conditioned on completing this authorization.

EXPIRATION:
This Authorization expires twelve (12) months from last date of SUD services by BHCS and/or SPN.

Disclosure Purpose	Amount and Kind
• Lawful holders of my protected SUD information may contact my emergency contact(s) in the event of an emergency, and thereby disclose that I am a patient being served in this SUD program.	• Limited to that information which is necessary to carry out the Disclosure Purpose • I permit lawful holders to re-disclose my protected SUD information subject to this authorization and 42 CFR part 2 • Other: _____

Signature of Patient	Print/Type Name	Date

Signature of Parent or Guardian	Print/Type Name		Date
		(☐) Parent (☐) Guardian	

REVOCATION AND REQUEST: I understand that I have a right to revoke this authorization at any time unless action has been taken in response to or in reliance on this authorization. I understand to contact a BHCS Health Information representative in order to revoke the authorization granted to BHCS. I further understand that I should provide a separate revocation to any other person or entity that I have authorized to disclose, receive, or otherwise use my individually identifiably SUD information above in order to revoke the authorization granted to that person or entity.

* SPN includes past, current, and future network providers. A directory of current network providers participating in the SPN is available at http://www.acbhcs.org/SUD/docs/SUD_providers_dirctory.pdf. I understand that I have a right to request a list of entities to which my patient identifying information has been disclosed pursuant to a general designation under this authorization and applicable regulations. I further understand that such a request must be in writing and limited to disclosures made within the past two years.

PROHIBITION ON RE-DISCLOSURE OF PROTECTED SUD INFORMATION: 42 CFR part 2 prohibits unauthorized disclosure of these records.

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AUTHORIZATION TO DISCLOSE MY INDIVIDUALLY IDENTIFIABLE SUD INFORMATION – GENERIC FORM

PATIENT INFORMATION

Last Name | First Name | Middle Initial

Date of Birth | Social Security No. | Home Phone | Work Phone | Extension

Street Address | City | State | Zip Code

I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE SUBSTANCE USE DISORDER (SUD) INFORMATION BE RELEASED FROM:

Name of Individual/Provider | Phone Number | Extension

Street Address | City | State | Zip Code

Name of Individual/Provider | Phone Number | Extension

Street Address | City | State | Zip Code

I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE SUD INFORMATION BE RELEASED TO AND USED BY:

Name of Individual/Provider | Phone Number | Extension

Street Address | City | State | Zip Code

Name of Individual/Provider | Phone Number | Extension

Street Address | City | State | Zip Code

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AUTHORIZATION TO DISCLOSE MY INDIVIDUALLY IDENTIFIABLE SUD INFORMATION – GENERIC FORM

EXPIRATION: This Authorization expires twelve (12) months from last date signed, unless the following is checked and expiration date entered: (☐) _____

Disclosure Purpose	Amount and Kind
• _____ • _____ • _____ • _____ • _____ • _____	• Limited to that information which is necessary to carry out the Disclosure Purpose • Other: _____

Signature of Patient	Print/Type Name	Date
_____	_____	_____

Signature of Parent or Guardian	Print/Type Name		Date
_____	_____	(☐) Parent (☐) Guardian	_____

REVOCATION AND REQUEST: I understand that I have a right to revoke this authorization at any time unless action has been taken in response to or in reliance on this authorization. I understand to contact a BHCS Health Information representative in order to revoke the authorization granted to BHCS. I further understand that I should provide a separate revocation to any other person or entity that I have authorized to disclose, receive, or otherwise use my individually identifiably SUD information above in order to revoke the authorization granted to that person or entity.

PROHIBITION ON RE-DISCLOSURE OF PROTECTED SUD INFORMATION: 42 CFR part 2 prohibits unauthorized disclosure of these records.