AUTHORIZATION FOR DISCLOSURE OF MY SUBSTANCE USE INFORMATION FOR PAYMENT & HEALTH CARE OPERATIONS (FORM 1)

Section 1. Client Information

First Name: _____ Last Name: _____ Middle Name: _____

ACBH Client ID # *(optional)*: _____ Date of Birth: _____

Section 2. Authorization to Disclose My Information & Purposes of Disclosure

By signing this form, I authorize the individual(s) and organization(s) in **Section 3** to disclose to the organizations in **Section 4** my information described in **Section 5** for the purposes below:

- **Payment:** For example, my information may be shared to allow my health care providers to get paid for services and figure out if I am eligible for services or benefits.
- **Health Care Operations:** For example, my information may be shared for administrative, financial, legal, and quality improvement activities necessary for an organization to run its business and to support my treatment and payment for my services.

Section 3. Names or Types of Organizations Disclosing My Information

- Alameda County Behavioral Health Care Services (ACBH)
- Any past, present, or future treating substance use disorder provider within the ACBH Substance Use Disorder Continuum of Care (for example, my substance use counselor)

Section 4. Names of Organizations Receiving My Information

- California Department of Health Care Services
- Alameda County Behavioral Health Care Services
- Other (write name): _____

Section 5. My Substance Use Treatment Information to Be Disclosed

I authorize all of the following **substance use** information to be disclosed:

- Service history
- Assessment information/ diagnosis
- Treatment plans
- Medications
- Progress notes
- Discharge plans / summary
- Drug and lab test results
- Other: _____

Section 6. Expiration of Authorization

This authorization will expire three (3) years after the date of my signature on this form, unless I write in another date or event here: _____.

Section 7. My Rights

- I do not have to sign this authorization form. However, if I do not sign this authorization form, I recognize I may be denied services because my provider may not be paid for these services.
- I may revoke this authorization at any time by contacting one of my providers listed in **Section 3** verbally or in writing, except to the extent an organization has already relied on this authorization to disclose my information.
- I have the right to receive a copy of this authorization form.

Section 8. Redisclosure of My Information

A strict federal law that protects substance use information (42 C.F.R. Part 2) prohibits redisclosure of my substance use information unless I specifically authorize in writing or the federal law allows the redisclosure.

Section 9. My Signature

At least one of the following below must be signed and dated to complete this form.

Client signature: _____ Date: _____

Legal representative signature: _____ Date: _____

If signed by a legal representative, the person signing must be authorized to sign this form on behalf of the client and present documentation demonstrating that authorization. Please describe the authority to sign on behalf of the client:

_____