Behavioral Health Department
Alameda County Health

FORM A

Consent For Use and Disclosure of Substance Use Information
For TREATMENT, PAYMENT & HEALTH CARE OPERATIONS or PAYMENT & HEALTH CARE OPERATIONS ONLY
(42 CFR PART 2)

Alameda County Health (AC Health) is committed to providing you with the highest quality care. AC Health includes multiple departments and programs, such as Behavioral Health, Public Health, Emergency Medical Services, Healthcare for Homeless, and Homelessness and Housing Services, among others. AC Health also contracts with community providers to deliver these essential services. To ensure you receive safe, coordinated, and effective care, our clinical team members need a complete understanding of your health history and the care you have received within the County and its affiliated providers. For this reason, the AC Health, Behavioral Health Department (ACBHD) is requesting your permission to use and disclose your substance use information for purposes of Treatment, Payment, and Health Care Operations. By signing this document, you authorize the use and disclosure of your substance use information as described below.

Behavioral Health Department
Alameda County Health

Section 1. Client Information		
Full Name: _____ (First Name) (Middle Initial) (Last Name)		
Clinic/Program Name: _____		
_____ **Medi-Cal CIN**	_____ **Date of Birth**	_____ **Phone Number**

Section 2. Consent to Use and Disclose and Purposes of Disclosure

By signing this form, I consent to allow the individuals and organizations in Section 3 to disclose to the individuals and organizations in Section 4 my information described in Section 5 for the purposes of (select only **ONE** of the following):

☐ **Treatment, Payment, and Health Care Operations (TPO)**

OR

☐ **Payment and Health Care Operations Only**

I ***do not authorize*** disclosure of my Part 2 records for Treatment purposes under this consent.

Examples of Treatment, Payment, and Health Care Operations are below.	
Treatment	For example, this allows a substance use provider to consult with my treatment providers (e.g., mental health, primary care) to improve my treatment plan or for ACBHD to coordinate my connection to housing services or public benefits.
Payment	For example, this allows my health care provider to share information to get paid for services and to determine my eligibility for services or benefits.
Health Care Operations	For example, this allows my information to be shared for administrative, financial, legal, auditing, 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 Organization Disclosing the Information
• Alameda County Health, Behavioral Health Department. • Any past, present, or future service provider(s) or organization(s) responsible for my Treatment, Payment, or Health Care Operations, including any organizations that assist them with these activities.

Section 4. Names of Organization Receiving the Information
• Alameda County Health, Behavioral Health Department. • California Department of Health Care Services. • Health Plan or Health Care Provider. • Any past, present, of future service provider(s) or organization(s) responsible for Treatment, Payment, or Health Care Operations, including any organizations that assist them with these activities.

Section 5. Description of Substance Use Treatment Information to be Disclosed
I consent to the disclosure of my substance use disorder information protected under 42 CFR Part 2 (including, but not limited to, diagnoses, medications, treatment records, and family and social history) for the purposes described in this consent form.

Section 6. Expiration

This consent will not expire, unless I write in an expiration date or event here: _____

Section 7. My Rights

- I understand that I do not have to sign this consent form. If I do not sign to at least authorize use and disclosure for the purpose of Payment and Health Care Operations, I may be denied access to programs or services that require disclosure of my substance use information.
- I may revoke this consent at any time by contacting the individuals or organizations that I do not want to disclose my information, except if they have already relied on this consent to disclose my information. My revocation may be made verbally or in writing.
- I have the right to receive a copy of this consent form.

Section 8. Redisclosure Notice

By signing this consent form, I am allowing disclosure of my substance use information as described above. The individuals or organizations listed in Section 4 may rely on this consent to use and disclose my information for Treatment, Payment, and Health Care Operations OR Payment and Health Care Operations (depending on what I checked in Section 2) only as permitted by law.

Once my information is used or disclosed under this consent, it may be further used or disclosed under the Health Insurance Portability and Accountability Act (HIPAA), instead of the stricter protections under 42 CFR Part 2. However, Part 2 still continues to prohibit the use and disclosure of my substance use information in criminal, civil, or administrative proceedings against me without my specific written consent or a court order.

Section 9. Signatures

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

_____ _____

Client Signature **Date**

If the client is a minor who has the legal authority to consent to their own substance use treatment under State law, the minor must sign the form. If you turn 18, or if your guardianship changes, you will need to provide new consent.

_____

Parent/Guardian or Authorized Representative PRINT NAME

Parent/Guardian/Authorized Representative SIGNATURE	**Date**

If signing on behalf of a minor, the person must be legally authorized to consent to disclosure of the minor's SUD information. Documentation of authority (e.g., guardianship papers, court order) must be provided. Please describe the authority: _____

42 CFR Part 2 prohibits unauthorized use or disclosure of these records