# Alameda County Behavioral Health Department (ACBHD) Substance Use Disorder (SUD) Consent Forms

ACBHD Quality Assurance (QA) Division


Presenters:

Torfeh Rejali, LMFT, QA Division Director

Brion Phipps, LCSW, Interim QA Associate Administrator


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Content Developed by:

Audrey Vera, LMFT

Brion Phipps, LCSW

Torfeh Rejali, LMFT

Karen Capece, LCSW

# Who Is This Training For?

All providers of substance use services affiliated with ACBHD:

1. SUD Residential
2. SUD Outpatient
3. Opioid Treatment Providers (OTP)/Narcotic Treatment Providers (NTPs)

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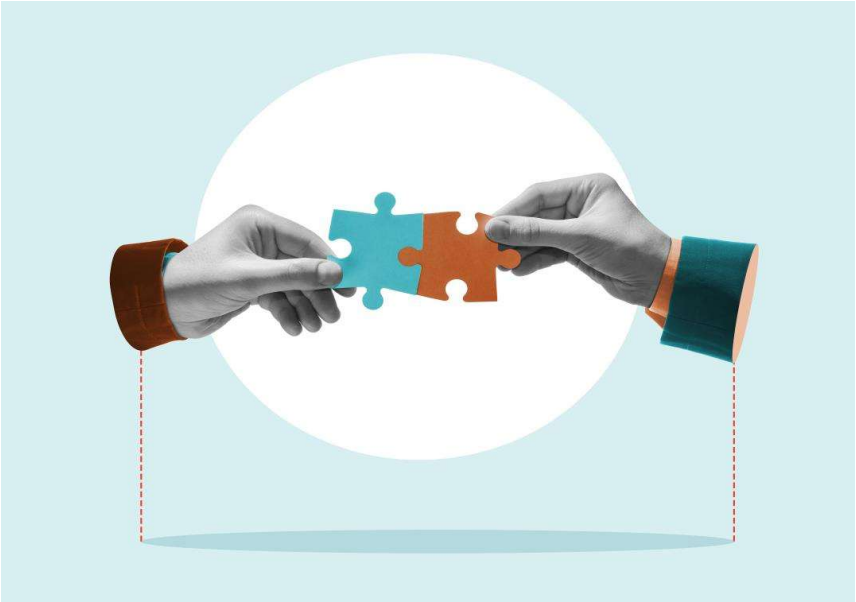
# Objectives

1. Provide overview of 2024 42 CFR Part 2 Final Rule changes
2. Introduce ACBHD Substance Use Disorder (SUD) Consent Forms
3. Discuss DHCS ASCMI Requirements
4. Communicate ACBHD SUD Consent implementation plan



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# Overview of 2024 42 Code of Federal Regulations (CFR) Part 2 Changes

# 42 CFR Part 2 Training Disclaimer

- This is not a comprehensive training on SUD privacy/confidentiality laws.
- It includes a brief overview and some relevant information about Part 2, but additional training is essential.
- As SUD providers have to navigate both substance use and mental health related privacy laws, both 42 CFR Part 2 and HIPAA training is necessary.
- Contracted providers are responsible for ensuring that their workforce is properly trained on both HIPAA and 42 CFR Part 2 Privacy requirements.

**Provider Training Reminder:**

- Per memo issued on June 8, 2026, providers are **required** to complete a series of self-paced modules titled **Substance Use Disorder (SUD) Privacy Compliance** by **October 31, 2026.**
- Additional recommended privacy training is available through:

Focus:PHI
The Center of Excellence for Protected Health Information
A partnership with CAI LAC LEGAL ACTION CENTER
Funded by SAMHSA Substance Abuse and Mental Health Services Administration

https://coephi.org

Code of Federal Regulations
A point in time eCFR system
Title 42

HIPAA COMPLIANT

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# 42 Code of Federal Regulations (CFR) Part 2 – Confidentiality of Substance Use Disorder Patient Records

**Purpose:**

- Commonly referred to as “Part 2” or “Part 2 Program”
- Federal regulations that protect the confidentiality of substance use disorder (SUD) patient records.
- Part 2 provides stronger privacy protections than HIPAA for SUD patient records.
- Providers generally cannot disclose any patient identifying information without written patient consent.[1]

**Recent Changes:**

Major rule changes in 2020 and 2024 modernized Part 2, aligning it more closely with HIPAA and enabling better care coordination while keeping core confidentiality protections.

[1] See 42 CFR §§ 2.12(d) and 2.51-2.54 for information about exceptions.

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# Impact of 2020/2024 42 CFR Part 2 Changes

| | |
|---|---|
| For Providers: | Providers may now share SUD records with other treating providers for **treatment**, **payment**, and **operations** with a **single** patient consent. |
| | Consent is no longer required for each individual disclosure to the care team, helping streamline **care coordination across providers.** |
| | Providers must still obtain a **separate written consent** before disclosing records to **third parties** (e.g., family, insurers, courts, employers). |
| | Records remain protected from use in criminal, civil, or administrative proceedings without patient consent or court order. |

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# Impact of 2020/2024 42 CFR Part 2 Changes (cont.)

| | |
|---|---|
| For Members: | One-time consent can authorize the entire care team to share SUD records. This reduces paperwork burden. |
| | Members retain the right to revoke consent at any time. |
| | Core confidentiality protections remain intact. SUD records cannot be used against members in legal proceedings without consent. |
| | Members must still be informed of their rights and how their information will be used before consenting. |

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# Knowledge Check

A Part 2 program is one that “receives federal assistance” and “holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment.”

- ❑ True
- ❑ False

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# Knowledge Check

A Part 2 program is one that “receives federal assistance” and “holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment.”

✓ True

❑ False

True. Additionally, co-occurring SUD and MH programs are often considered Part 2 programs.

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# Knowledge Check

SUD programs don’t need to follow HIPAA.

- ❑ True
- ❑ False

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# Knowledge Check

SUD programs don’t need to follow HIPAA.

❑ True

✓ False

HIPAA applies to all types of health care records, including mental health, substance use, and physical health. With the 2024 changes, Part 2, is even more closely aligned with HIPAA.

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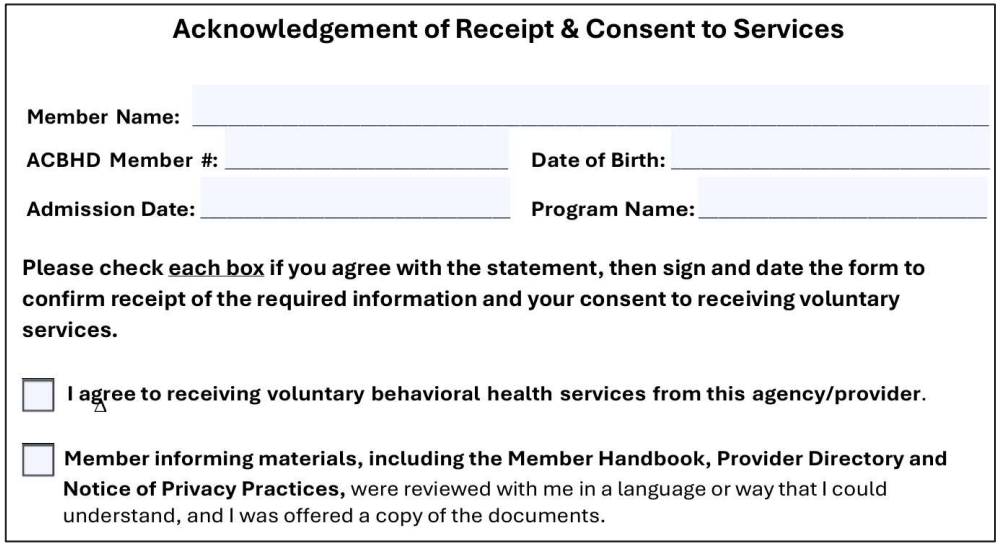
# ACBHD SUD Consents

# Consent to Treatment

- There are no changes to the requirement to obtain consent to treatment.
- Providers are required to use the **Acknowledgement of Receipt & Consent to Services** form found on the ACBHD Informing Materials provider page at the start of treatment.



**Acknowledgement of Receipt & Consent to Services**

**Member Name:** _____

**ACBHD Member #:** _____ **Date of Birth:** _____

**Admission Date:** _____ **Program Name:** _____

**Please check each box if you agree with the statement, then sign and date the form to confirm receipt of the required information and your consent to receiving voluntary services.**

☐ **I agree to receiving voluntary behavioral health services from this agency/provider.**

☐ **Member informing materials, including the Member Handbook, Provider Directory and Notice of Privacy Practices,** were reviewed with me in a language or way that I could understand, and I was offered a copy of the documents.

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# Consent to Disclose Substance Use Information

- There are several new forms that must be used to obtain consent to disclose substance use information and are available in Section 11 of the QA Manual:

    1) **ACBHD Consent for TPO or PO Only (Form A)**
    2) **ACBHD Consent for Other Purposes (Form B)**
    3) **DHCS ASCMI Non-AB133 Form**

- Previous ACBHD Consent forms have been removed from the provider website.
- ACBHD SUD consents are required for all services that are part of your agency's ACBHD contract.
- The ACBHD SUD consent forms are currently being translated into the county's threshold languages and will be available shortly.
- Translated versions of the ASCMI are available on the DHCS ASCMI webpage.

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# Provider Website

## QA Manual page- Section 11

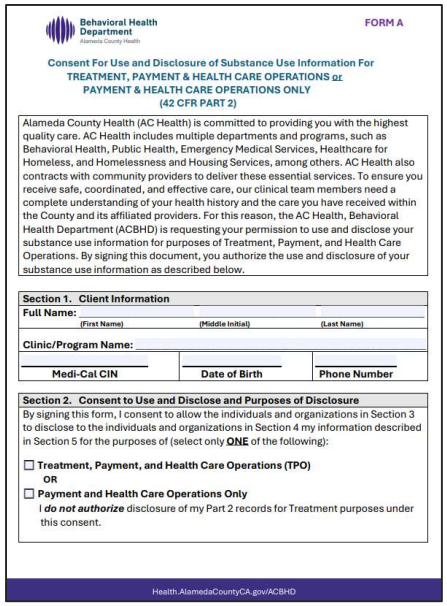
| | | |
|---|---|---|
| **11** | | **CONFIDENTIALITY POLICIES** |
| | 11-1 | PRIVACY, SECURITY AND CONFIDENTIALITY STATEMENT OF CLIENT SERVICES, RECORDS AND INFORMATION - **REVISED 5/10/24** |
| | 11-2 | SMARTSHEET PRIVACY INCIDENT REPORT FORM - **REVISED 5/23** |
| | 11-3 | RECORD AND DATA RETENTION AND DESTRUCTION OF PROTECTED HEALTH INFORMATION |
| | 11-4 | PRIVACY PULSE - SECURE EMAIL COMMUNICATIONS - **NEW 7/2/26** |
| | 11-5 | RELEASE OF INFORMATION FORMS AND RESOURCES |

- Form A. SUD TPO and PO Consent - **NEW 8/12/26**
- Form B. SUD Consent for Other Purposes - **NEW 8/12/26**
- State's ASCMI Forms - **NEW 8/12/26**

## Informing Materials Page

6. **Acknowledgement of Receipt & Consent to Services - Updated 3/3/26**
   - Following review of the above information, the "Acknowledgement of Receipt & Consent to Services" page must be signed and dated by the member, acknowledging that the material has been reviewed, or re-reviewed, with them and providing their consent to receive services.
   - Providers may add their logo or additional content to the Acknowledgement of Receipt and Consent to Services signature page but may not remove or alter any of the information on the form.
   - The signed Acknowledgement of Receipt page should be retained in the member's clinical record and provided to ACBHD and/or DHCS upon request.
   - In case of a substantial change to the content, the changes must be reviewed with the member and a new signature and date obtained and saved in the member's clinical record.
     - Acknowledgement of Receipt - Fillable: English, Spanish, Arabic, Simplified Chinese, Chinese Traditional, Farsi, Korean, Vietnamese, and Tagalog
     - Acknowledgement of Receipt - Large Format: English, Spanish, Arabic, Simplified Chinese, Chinese Traditional, Farsi, Korean, Vietnamese, and Tagalog

# ACBHD SUD Consent Form A: TPO or PO only



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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.

**Section 1. Client Information**

**Full Name:** _____
(First Name) (Middle Initial) (Last Name)

**Clinic/Program Name:** _____

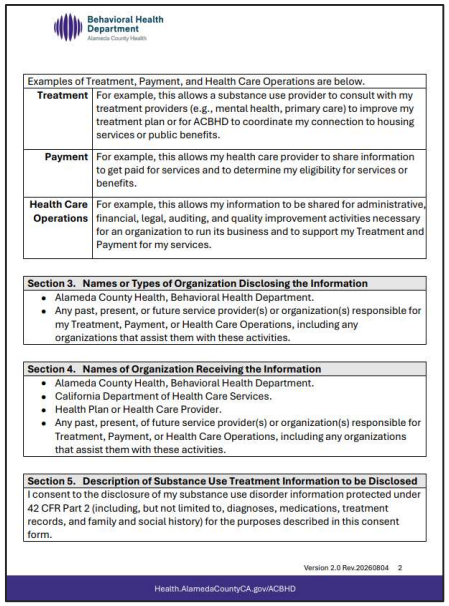
| Medi-Cal CIN | Date of Birth | Phone Number |
|---|---|---|
| | | |

**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.

Health.AlamedaCountyCA.gov/ACBHD



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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.

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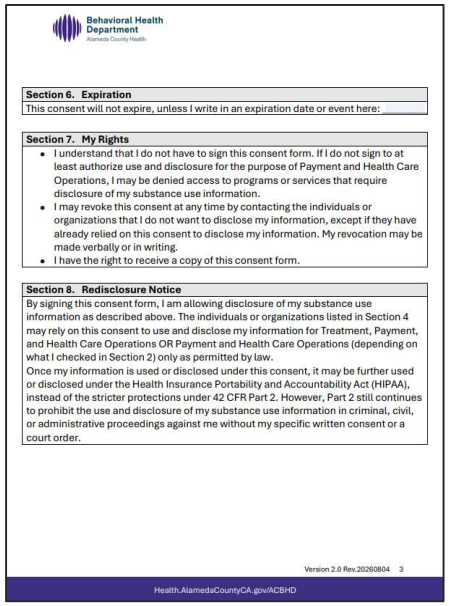

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**Section 6. Expiration**

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.

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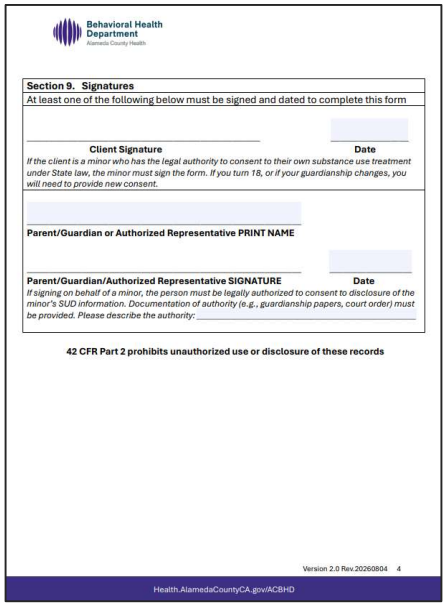

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**Section 9. Signatures**

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**

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Available for download in section 11 of the ACBHD QA Manual Provider Site

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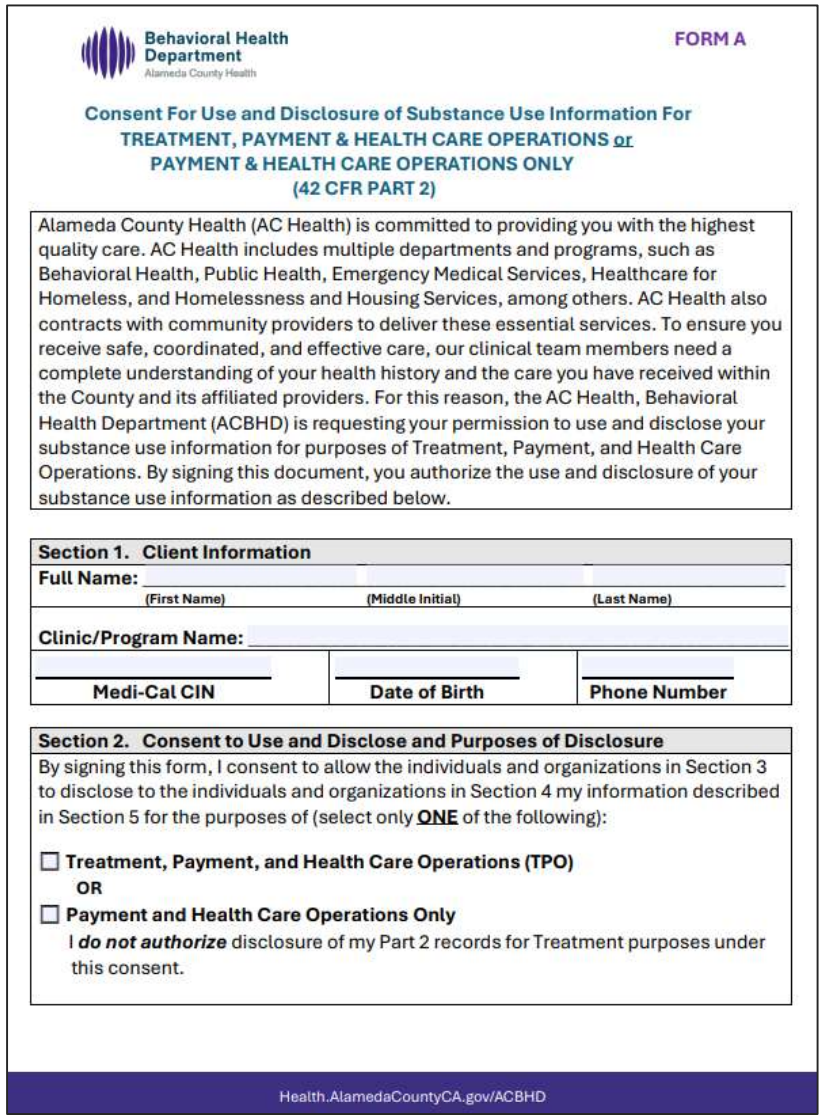
# ACBHD SUD Consent Form A: TPO or PO only

- ACBHD SUD Consent Form A is a Part 2 compliant consent form that functions as a **Treatment, Payment, and Operations** (TPO), or **Payment and Operations** (PO) **only**, consent form depending on the options checked.
- **It is a simple and short form and should be presented to members first.**
- In the *Consent to Use and Disclose* section of the form, only ONE option may be selected.
- Form A must at least have the PO checkbox endorsed to share information with ACBHD for claiming and operations purposes.



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.

**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**

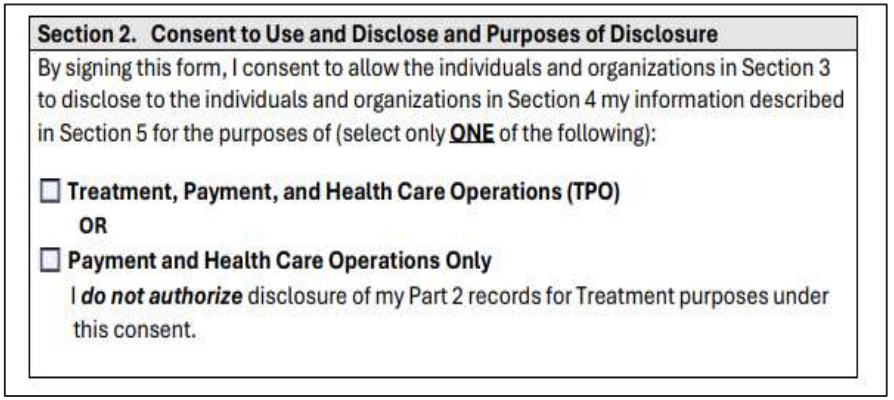
I ***do not authorize*** disclosure of my Part 2 records for Treatment purposes under this consent.

Health.AlamedaCountyCA.gov/ACBHD

# ACBHD SUD Consent Form A: TPO or PO only (cont.)

**When the TPO box is checked:**

- Minimum necessary SUD PHI may be shared outside of your agency with other ***county*** providers, care coordinators, and health plans for the purposes of care coordination without the need for additional consents.
- Minimum necessary SUD PHI may be shared with ACBHD for the purposes of payment and operations.



**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.

**When the "Payment and Health Care Operations Only" box is checked:**

- Minimum necessary SUD PHI may be shared with ACBHD for payment and operations only.
- SUD PHI may not be shared with care providers for care coordination purposes unless additional releases are signed.

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# ACBHD SUD Consent Form A: TPO or PO only (cont.)

Use cases include:

- A member is receiving mental health and SUD treatment at different organizations.
  - On the **ACBHD Consent for TPO or PO Only (Form A),** if the **TPO box is checked,** the consent authorizes providers from both covered-entities to share records and align treatment plans without separate ROIs for each disclosure.
- A member receiving both behavioral health treatment and housing support services needs their providers to communicate.
  - If the **TPO box is checked,** the consent authorizes sharing relevant health and social services information with housing organizations involved in their care.

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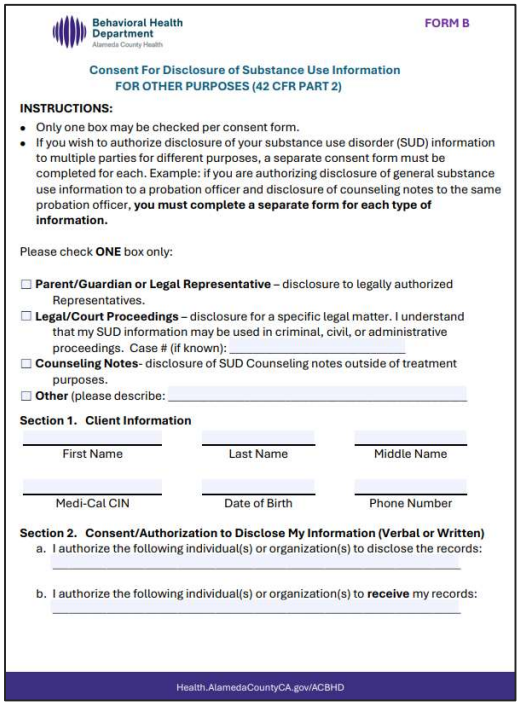
# ACBHD SUD Consent Form B: For Other Purposes



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FORM B

**Consent For Disclosure of Substance Use Information**
**FOR OTHER PURPOSES (42 CFR PART 2)**

**INSTRUCTIONS:**

- Only one box may be checked per consent form.
- If you wish to authorize disclosure of your substance use disorder (SUD) information to multiple parties for different purposes, a separate consent form must be completed for each. Example: if you are authorizing disclosure of general substance use information to a probation officer and disclosure of counseling notes to the same probation officer, **you must complete a separate form for each type of information.**

Please check **ONE** box only:

☐ **Parent/Guardian or Legal Representative** – disclosure to legally authorized Representatives.
☐ **Legal/Court Proceedings** – disclosure for a specific legal matter. I understand that my SUD information may be used in criminal, civil, or administrative proceedings. Case # (if known): _____
☐ **Counseling Notes**- disclosure of SUD Counseling notes outside of treatment purposes.
☐ **Other** (please describe): _____

**Section 1. Client Information**

First Name | Last Name | Middle Name

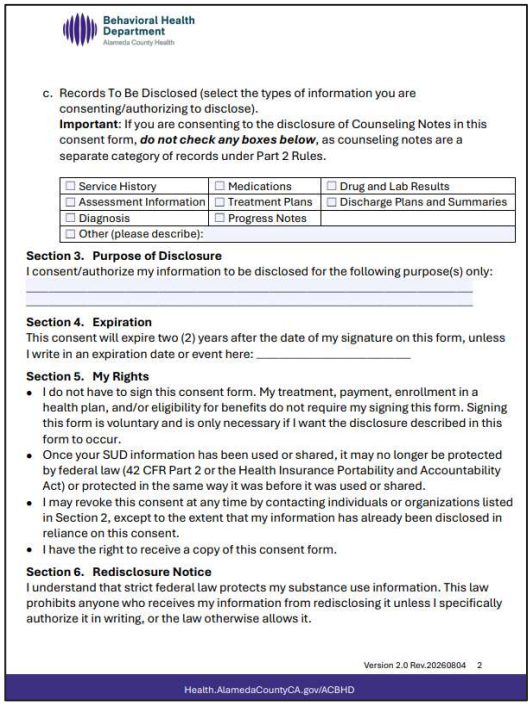
Medi-Cal CIN | Date of Birth | Phone Number

**Section 2. Consent/Authorization to Disclose My Information (Verbal or Written)**

a. I authorize the following individual(s) or organization(s) to disclose the records:

b. I authorize the following individual(s) or organization(s) to **receive** my records:

Health.AlamedaCountyCA.gov/ACBHD



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c. Records To Be Disclosed (select the types of information you are consenting/authorizing to disclose).
**Important**: If you are consenting to the disclosure of Counseling Notes in this consent form, ***do not check any boxes below***, as counseling notes are a separate category of records under Part 2 Rules.

| | | |
|---|---|---|
| ☐ Service History | ☐ Medications | ☐ Drug and Lab Results |
| ☐ Assessment Information | ☐ Treatment Plans | ☐ Discharge Plans and Summaries |
| ☐ Diagnosis | ☐ Progress Notes | |
| ☐ Other (please describe): | | |

**Section 3. Purpose of Disclosure**
I consent/authorize my information to be disclosed for the following purpose(s) only:

**Section 4. Expiration**
This consent will expire two (2) years after the date of my signature on this form, unless I write in an expiration date or event here: _____

**Section 5. My Rights**

- I do not have to sign this consent form. My treatment, payment, enrollment in a health plan, and/or eligibility for benefits do not require my signing this form. Signing this form is voluntary and is only necessary if I want the disclosure described in this form to occur.
- Once your SUD information has been used or shared, it may no longer be protected by federal law (42 CFR Part 2 or the Health Insurance Portability and Accountability Act) or protected in the same way it was before it was used or shared.
- I may revoke this consent at any time by contacting individuals or organizations listed in Section 2, except to the extent that my information has already been disclosed in reliance on this consent.
- I have the right to receive a copy of this consent form.

**Section 6. Redisclosure Notice**
I understand that strict federal law protects my substance use information. This law prohibits anyone who receives my information from redisclosing it unless I specifically authorize it in writing, or the law otherwise allows it.

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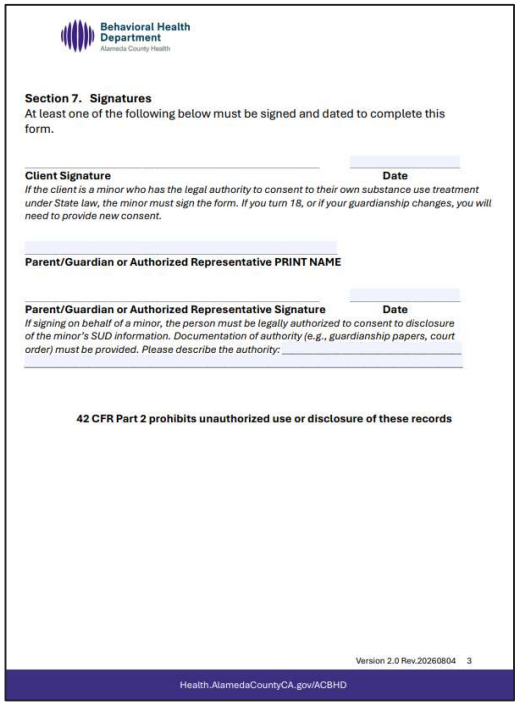

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**Section 7. Signatures**
At least one of the following below must be signed and dated to complete this form.

**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 or 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**

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Available for download on the ACBHD QA Manual Provider Site

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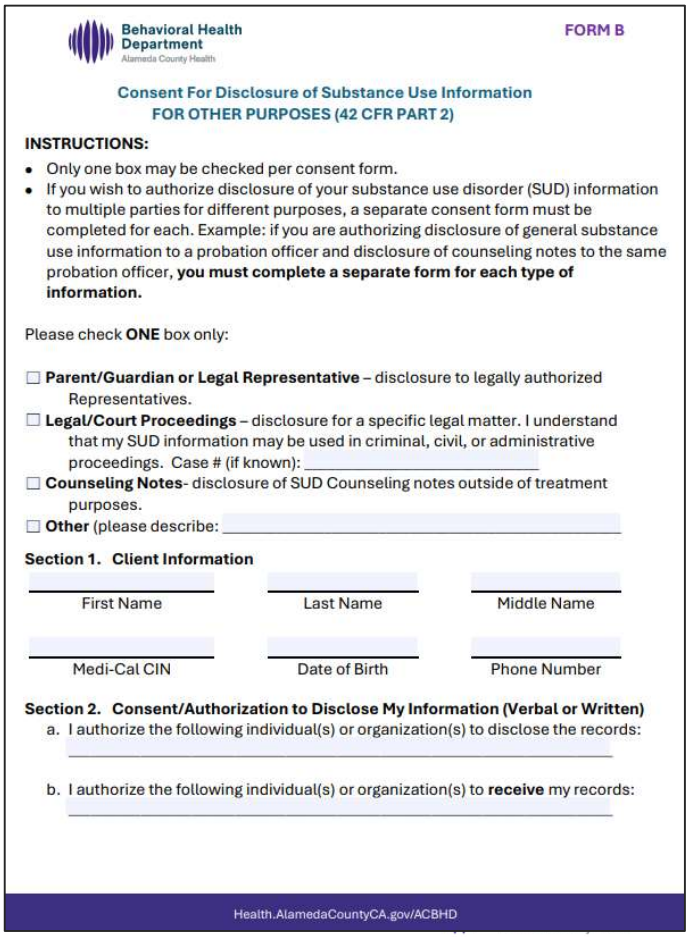
# ACBHD SUD Consent Form B: For Other Purposes, cont.

- **ACBHD Consent for Other Purposes (Form B)** is a consent form for Other Purposes.
- It is used to share information with non-covered entities.
- **Each use disclosure requires its own authorization**.
- Some examples of non-covered entities include family, employers, law enforcement, schools, drug court, and probation.
- This Consent does not substitute **ACBHD Consent for TPO or PO Only (Form A)** or the DHCS ASCMI**.**
- Form B is always required for disclosures made to an external party not covered by Form A or the DHCS ASCMI.



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Alameda County Health

FORM B

**Consent For Disclosure of Substance Use Information FOR OTHER PURPOSES (42 CFR PART 2)**

**INSTRUCTIONS:**

- Only one box may be checked per consent form.
- If you wish to authorize disclosure of your substance use disorder (SUD) information to multiple parties for different purposes, a separate consent form must be completed for each. Example: if you are authorizing disclosure of general substance use information to a probation officer and disclosure of counseling notes to the same probation officer, **you must complete a separate form for each type of information.**

Please check **ONE** box only:

☐ **Parent/Guardian or Legal Representative** – disclosure to legally authorized Representatives.
☐ **Legal/Court Proceedings** – disclosure for a specific legal matter. I understand that my SUD information may be used in criminal, civil, or administrative proceedings. Case # (if known): _____
☐ **Counseling Notes**- disclosure of SUD Counseling notes outside of treatment purposes.
☐ **Other** (please describe: _____

**Section 1. Client Information**

First Name | Last Name | Middle Name

Medi-Cal CIN | Date of Birth | Phone Number

**Section 2. Consent/Authorization to Disclose My Information (Verbal or Written)**

a. I authorize the following individual(s) or organization(s) to disclose the records:

b. I authorize the following individual(s) or organization(s) to **receive** my records:

Health.AlamedaCountyCA.gov/ACBHD

# SUD Consent for Other Purposes (Form B) (cont.)

Use cases include:

- A member's probation officer requests confirmation of treatment attendance.
  - **ACBHD Consent for Other Purposes (Form B)** authorizes that specific disclosure to the court.

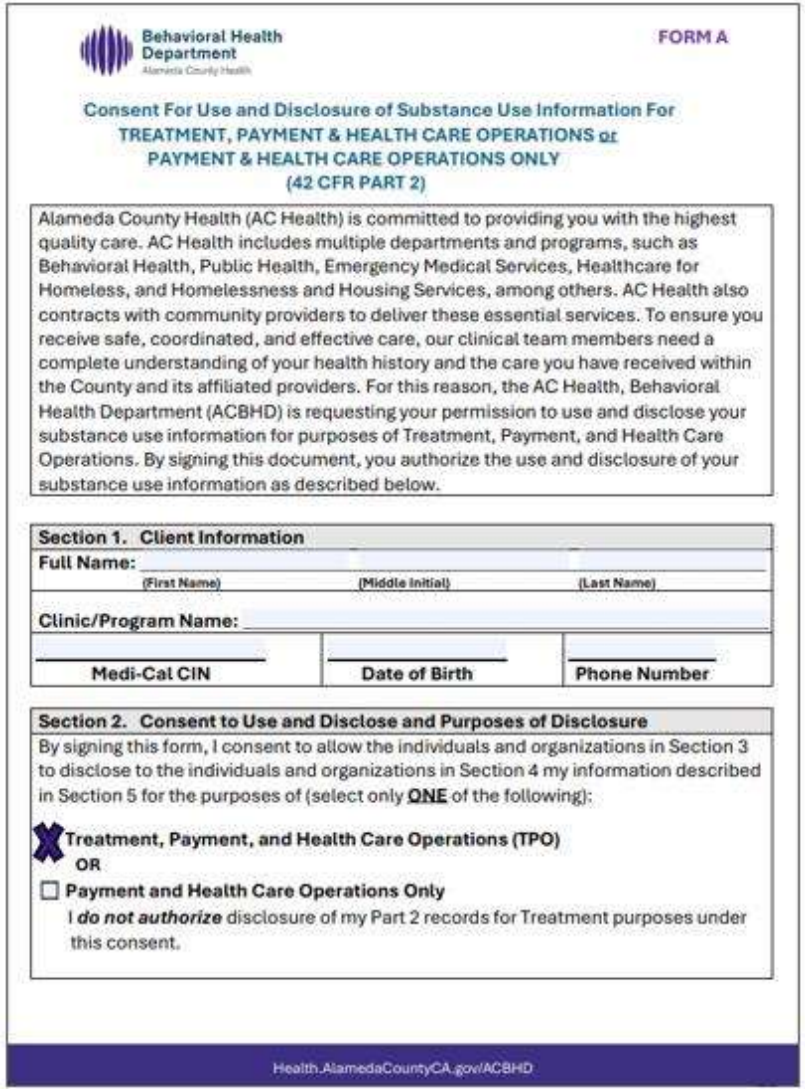
- A member's family member calls requesting an update on their treatment progress.
  - **ACBHD Consent for Other Purposes (Form B)** is completed to authorize the provider to speak with or share information with that specific family member.

Behavioral Health Department
Alameda County Health

# Knowledge Check

My client signed the **ACBHD Consent for TPO or PO Only (Form A)** at admission, **checking the TPO box.** I want to coordinate care with their mental health therapist. Do I need a separate ROI to contact the therapist?

- ❑ Yes
- ❑ No



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.

**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.

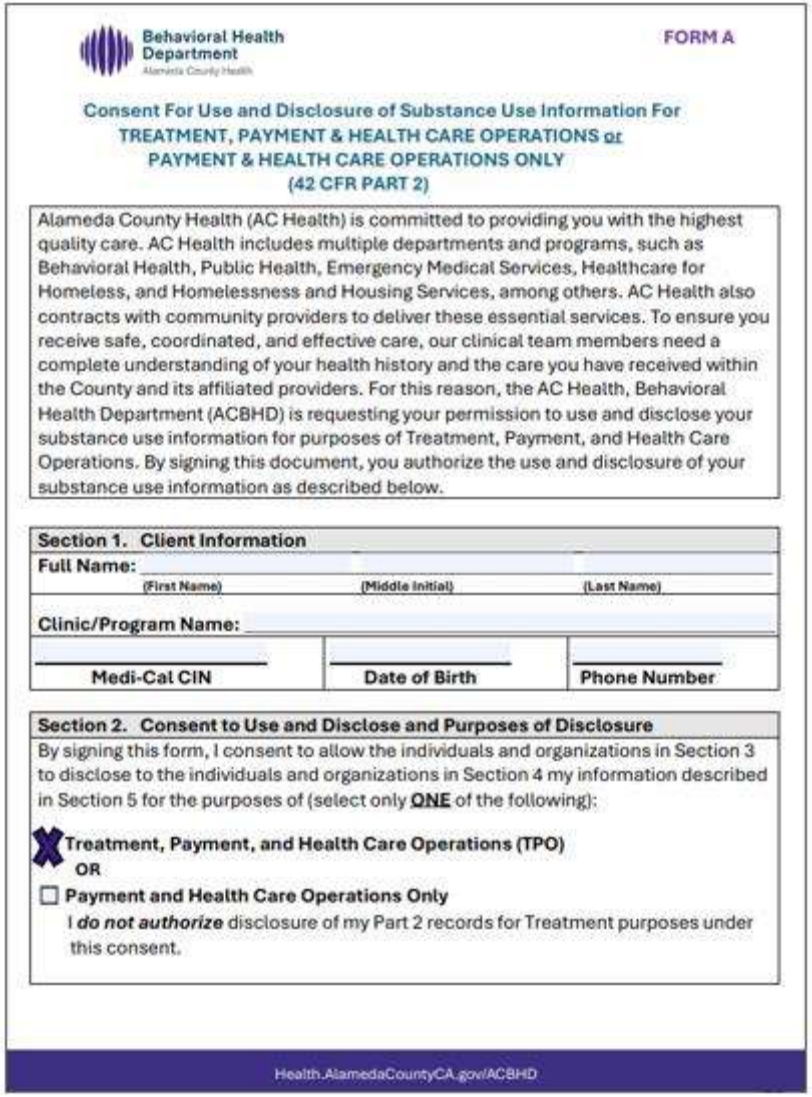
Health.AlamedaCountyCA.gov/ACBHD

# Knowledge Check

My client signed the **ACBHD Consent for TPO or PO Only (Form A)** at admission, **checking the TPO box.** I want to coordinate care with their mental health therapist. Do I need a separate ROI to contact the therapist?

❑ Yes
✓No

No, you don't need a separate ROI as the TPO allows sharing of PHI between covered entities.



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.

**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.

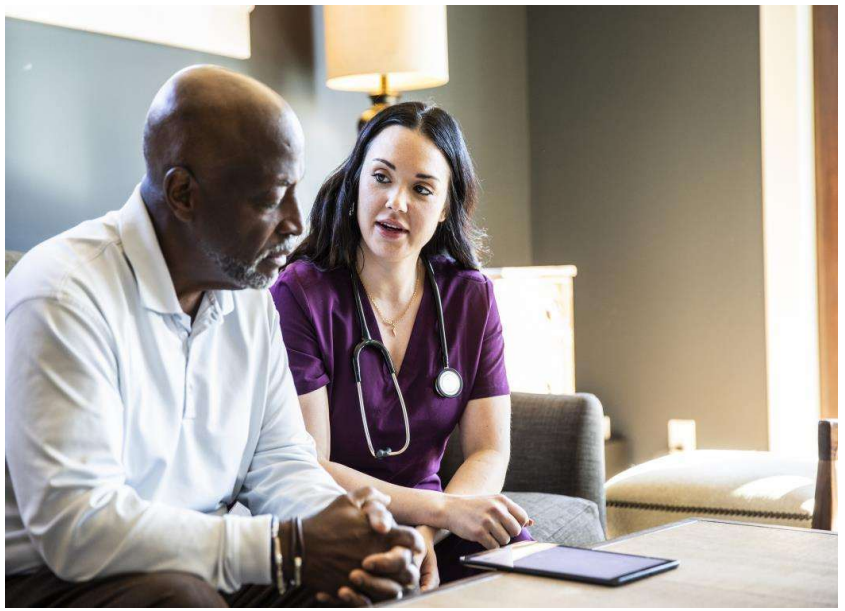
Health.AlamedaCountyCA.gov/ACBHD

# Knowledge Check

A potential member *declines* to sign **ACBHD Consent for TPO or PO Only (Form A)** but *agrees* to sign **ACBHD Consent for Other Purposes (Form B)**.

Since they signed Form B it is ok to claim ACBHD for their SUD treatment?

- ❑ True
- ❑ False



Behavioral Health Department
Alameda County Health

# Knowledge Check

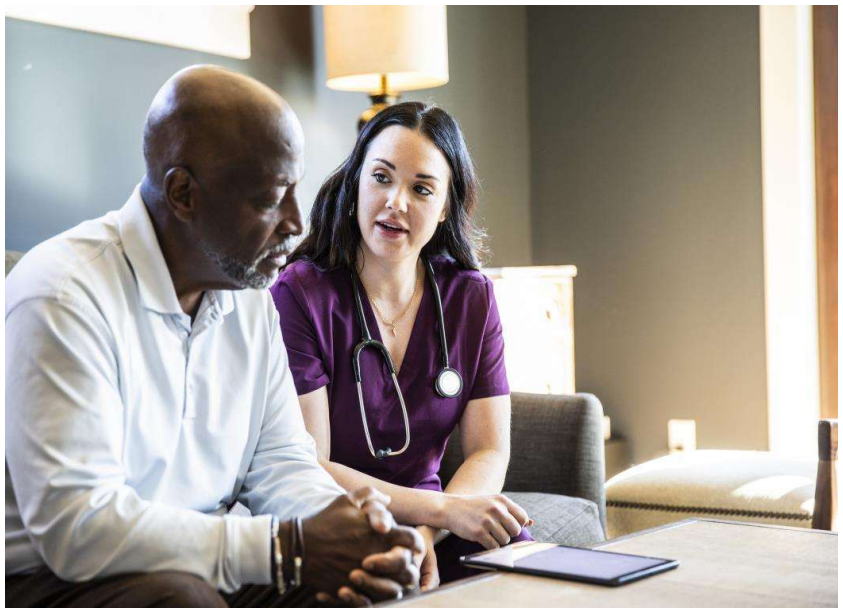
A potential member *declines* to sign **ACBHD Consent for TPO or PO Only (Form A)** but *agrees* to sign **ACBHD Consent for Other Purposes (Form B)**.

Since they signed Form B it is ok to claim ACBHD for their SUD treatment?

❑ True

✓ False

Members need to sign Form A or the ASCMI before claims information can be shared with ACBHD.

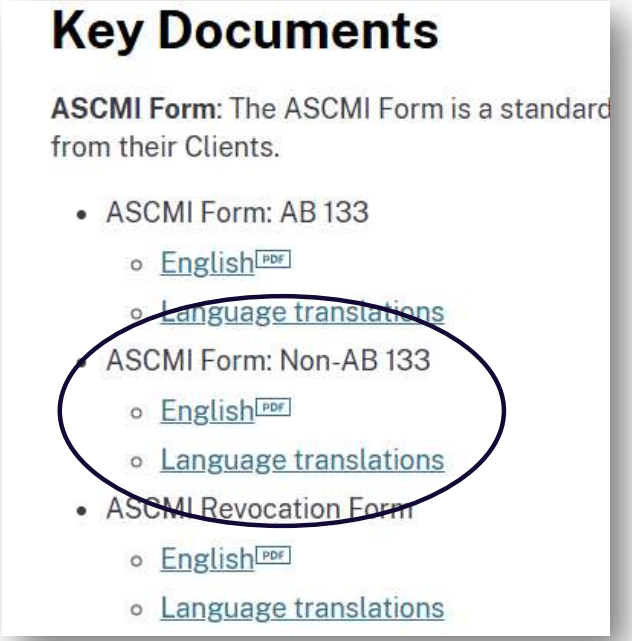


Behavioral Health Department
Alameda County Health

# DHCS CalAIM ASCMI Initiative and Forms

# DHCS CalAIM ASCMI Initiative

- The Authorization to Share Confidential Member Information or "ASCMI" Initiative is a statewide effort to promote and standardize the exchange of clients' sensitive information, including certain physical health, behavioral health, and social services information (HSSI), among Care Partners such as providers, health plans, county agencies, and social services organizations.
- DHCS has developed two versions of the ASCMI and a revocation form.
- ACBHD is implementing the **ASCMI Non-AB 133** version as it doesn't have to be re-signed when one's Medi-Cal eligibility changes.
- **Counties are <u>required</u> to implement DHCS data sharing requirements, including use of the ASCMI before January 1, 2027.**



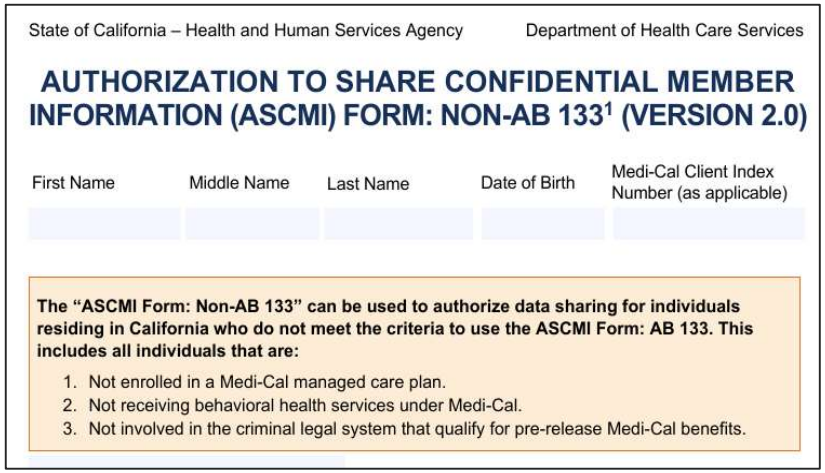

DHCS ASCMI Website
DHCS ASCMI FAQs

Behavioral Health Department
Alameda County Health

# DHCS ASCMI Non-AB 133 Form

The **ASCMI Non-AB 133 Form** is:

- Compliant with both HIPAA and 42 CFR Part 2.
- Applicable to any Californian, regardless of Medi-Cal enrollment, county, or program type.
- Used to obtain member's consent to use and disclose their health information among ***statewide*** providers, care coordinators, and health plans to support care coordination (e.g. when a member is hospitalized out-of-county).



State of California – Health and Human Services Agency  Department of Health Care Services

**AUTHORIZATION TO SHARE CONFIDENTIAL MEMBER INFORMATION (ASCMI) FORM: NON-AB 133[1] (VERSION 2.0)**

| First Name | Middle Name | Last Name | Date of Birth | Medi-Cal Client Index Number (as applicable) |
|---|---|---|---|---|
| | | | | |

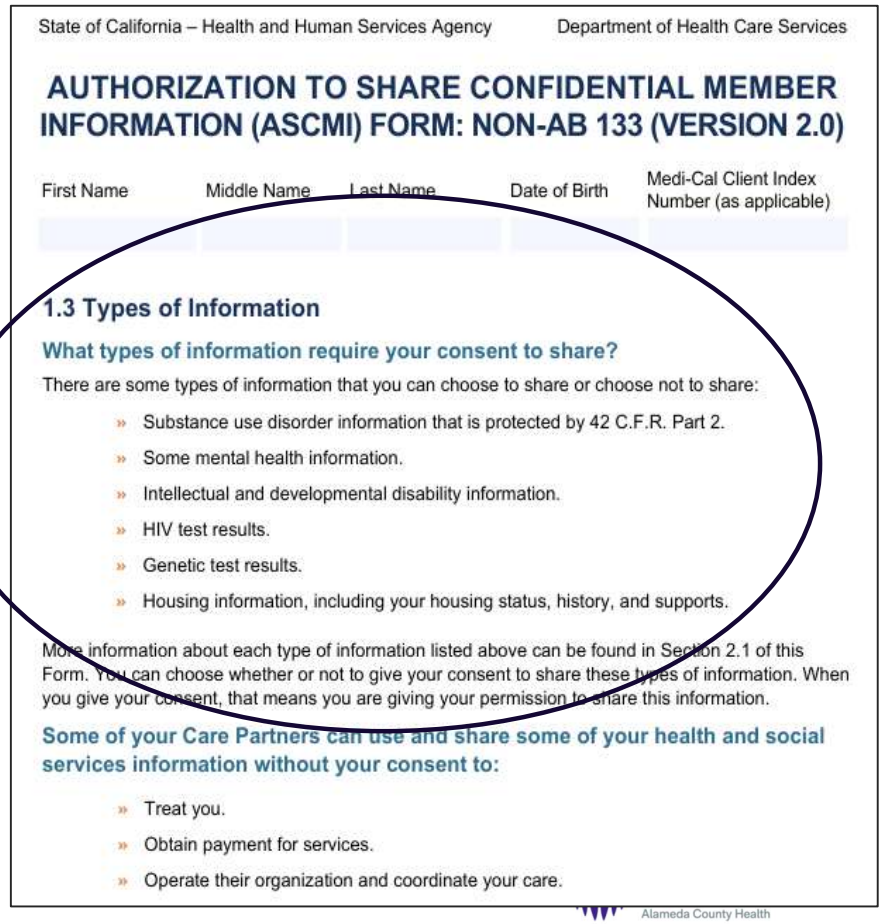
**The "ASCMI Form: Non-AB 133" can be used to authorize data sharing for individuals residing in California who do not meet the criteria to use the ASCMI Form: AB 133. This includes all individuals that are:**

1. Not enrolled in a Medi-Cal managed care plan.
2. Not receiving behavioral health services under Medi-Cal.
3. Not involved in the criminal legal system that qualify for pre-release Medi-Cal benefits.

Behavioral Health Department
Alameda County Health

# DHCS ASCMI Non-AB 133 Form

- The ASCMI allows members to consent to sharing of information involving SUD as well as other health information.
- **The ASCMI is required to be presented to members and should be reviewed after the *ACBHD SUD Consent Form A: TPO or PO only*.**
- Providers should explain that signing this form allows for appropriate care coordination across the **State**. For example, if the member is hospitalized outside of the county, this form will allow the provider to share relevant health information with their care team in the other county.
- Members are not required to sign the ASCMI to receive ACBHD SUD services.



State of California – Health and Human Services Agency Department of Health Care Services

**AUTHORIZATION TO SHARE CONFIDENTIAL MEMBER INFORMATION (ASCMI) FORM: NON-AB 133 (VERSION 2.0)**

| First Name | Middle Name | Last Name | Date of Birth | Medi-Cal Client Index Number (as applicable) |
|---|---|---|---|---|
| | | | | |

**1.3 Types of Information**

**What types of information require your consent to share?**

There are some types of information that you can choose to share or choose not to share:

- Substance use disorder information that is protected by 42 C.F.R. Part 2.
- Some mental health information.
- Intellectual and developmental disability information.
- HIV test results.
- Genetic test results.
- Housing information, including your housing status, history, and supports.

More information about each type of information listed above can be found in Section 2.1 of this Form. You can choose whether or not to give your consent to share these types of information. When you give your consent, that means you are giving your permission to share this information.

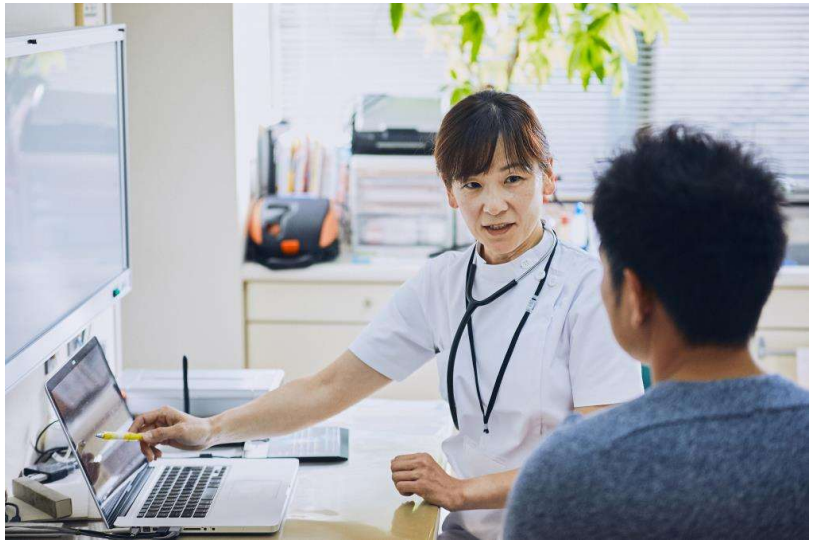
**Some of your Care Partners can use and share some of your health and social services information without your consent to:**

- Treat you.
- Obtain payment for services.
- Operate their organization and coordinate your care.

# DHCS ASCMI Non-AB 133 Form (cont.)

Use cases include:

- A member receiving SUD treatment relocates to Sacramento County.
  - The new provider can access prior treatment records without requiring a new consent process from scratch.
- A member's Medi-Cal status changes and switches insurance plans from ACBHD network.
  - The existing ASCMI on file is saved in DHCS's database by the new provider, eliminating redundant consent collection.



Behavioral Health Department
Alameda County Health

# Knowledge Check


Since the ASCMI does not have to be signed by the member to receive ACBHD SUD services, providers don't need to offer it to members for signature?

- ❑ True
- ❑ False

Behavioral Health Department
Alameda County Health

# Knowledge Check

Since the ASCMI does not have to be signed by the member to receive ACBHD SUD services, providers don't need to offer it to members for signature?

❑ True

✓ False

False. While a member may decline to sign the ASCMI, providers are required to present it to members after the *ACBHD SUD Consent Form A: TPO or PO only*.

Behavioral Health Department
Alameda County Health

# Expiration, Revocation and Tracking/Sharing Consent Forms

# Consent Expiration

- **ACBHD Consent for TPO or PO Only (Form A)**
  - Form A has no set expiration date. Members are able to add their own date to the form.

**Section 6. Expiration**
This consent will not expire, unless I write in an expiration date or event here: _____

- **ACBHD Consent for Other Purposes (Form B)**
  - Form B has a set expiration date of 2 years but the date can be adjusted by the member.

**Section 4. Expiration**
This consent will expire two (2) years after the date of my signature on this form, unless I write in an expiration date or event here: _____

- **DHCS CalAIM ASCMI**:
  - The ASCMI has a set expiration of one year for those 18 years old or older.

**How long does your consent to share your information last?**

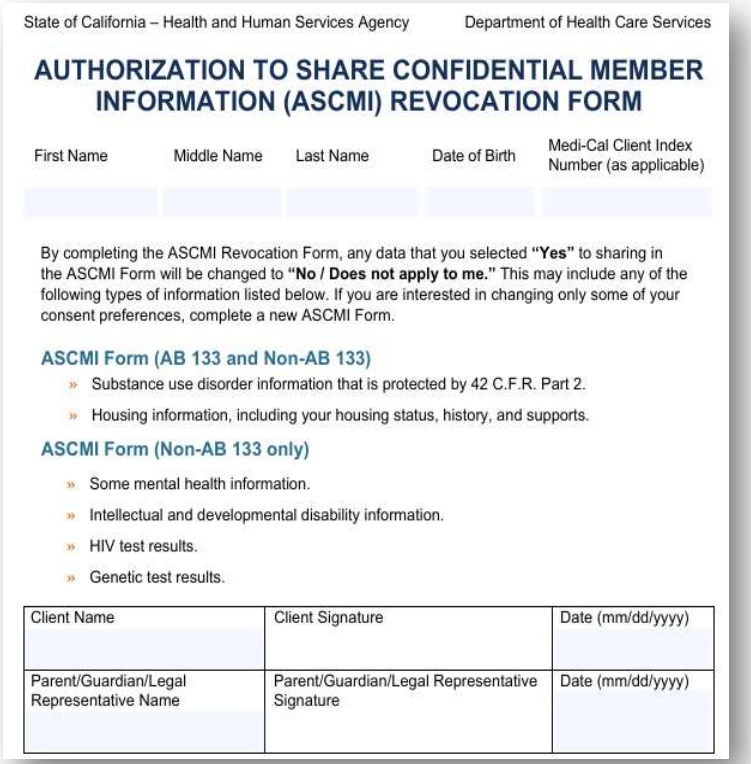
- **If you are age 18 or older**, this consent will last for one year from the date you signed the Form.
- **If you are under age 18,** your consent will last for one year from the date you signed the Form. If you turn 18, or if your guardianship changes, during this one-year period, you will need to provide new consent.

- For all consent forms, if under 18 years of age, a new signed consent is required when the member turns 18 or when their guardianship changes.

Behavioral Health Department
Alameda County Health

# Consent Revocation

- At any time, individuals have the right to revoke consent to share information.
- Revoking consent authorized by **ACBHD SUD Consent forms:**
  - Members should contact their provider and notify them of their desire to revoke their consent either verbally or in writing.
  - Providers with whom the consent was previously shared should be notified of it's revocation going forward.
- Revoking consent authorized by a **DHCS ASCMI** form:
  - Use the **DHCS ASCMI Revocation Form** found on the DHCS ASCMI website.



State of California – Health and Human Services Agency Department of Health Care Services

**AUTHORIZATION TO SHARE CONFIDENTIAL MEMBER INFORMATION (ASCMI) REVOCATION FORM**

| First Name | Middle Name | Last Name | Date of Birth | Medi-Cal Client Index Number (as applicable) |
|---|---|---|---|---|
| | | | | |

By completing the ASCMI Revocation Form, any data that you selected **"Yes"** to sharing in the ASCMI Form will be changed to **"No / Does not apply to me."** This may include any of the following types of information listed below. If you are interested in changing only some of your consent preferences, complete a new ASCMI Form.

**ASCMI Form (AB 133 and Non-AB 133)**

- Substance use disorder information that is protected by 42 C.F.R. Part 2.
- Housing information, including your housing status, history, and supports.

**ASCMI Form (Non-AB 133 only)**

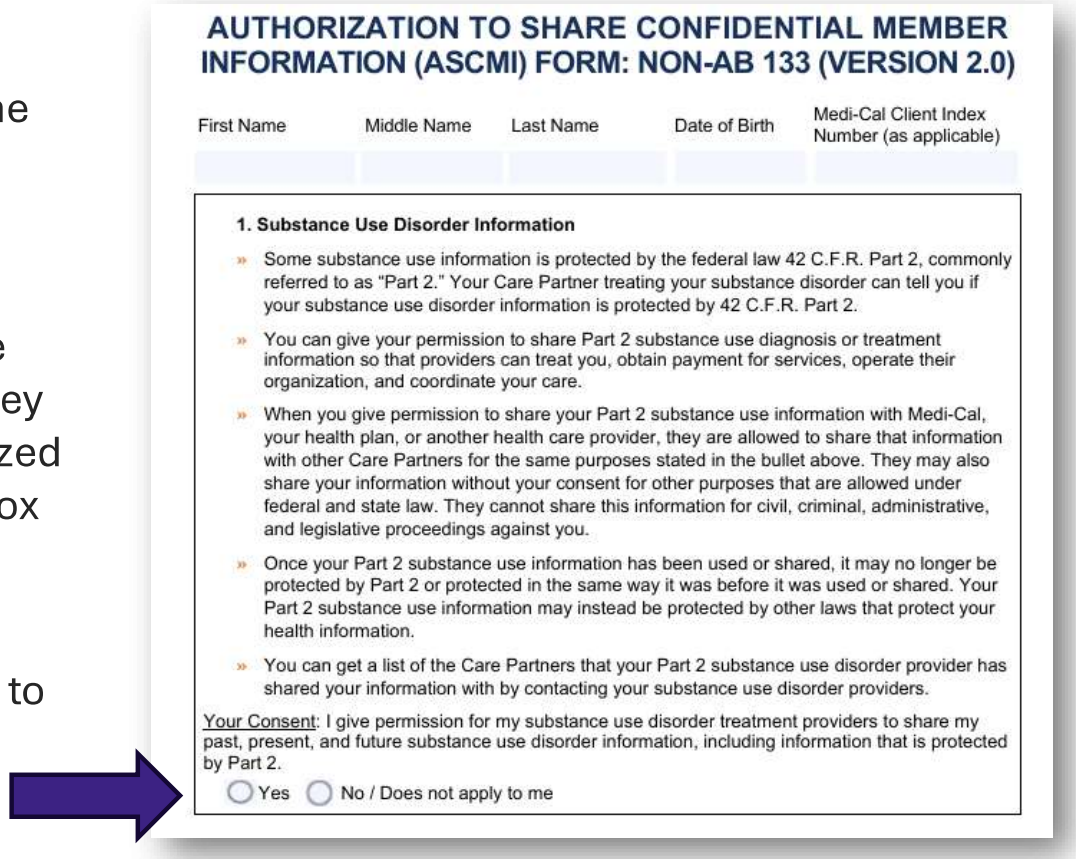
- Some mental health information.
- Intellectual and developmental disability information.
- HIV test results.
- Genetic test results.

| Client Name | Client Signature | Date (mm/dd/yyyy) |
|---|---|---|
| Parent/Guardian/Legal Representative Name | Parent/Guardian/Legal Representative Signature | Date (mm/dd/yyyy) |

Behavioral Health Department
Alameda County Health

# Tracking/Sharing Consent Forms

- All consent and revocation forms must be saved in the member's medical record. The form must be accessible in the record to document the basis for any subsequent information-sharing activities.
- DHCS requires providers to document the member's consent preferences, even if they decline the disclosure of any data authorized by the Form by selecting the "No" checkbox and indicating the client declined to sign.
- This avoids re-requesting their consent to share their data and records their request to not share that data.



**AUTHORIZATION TO SHARE CONFIDENTIAL MEMBER INFORMATION (ASCMI) FORM: NON-AB 133 (VERSION 2.0)**

| First Name | Middle Name | Last Name | Date of Birth | Medi-Cal Client Index Number (as applicable) |
|---|---|---|---|---|
| | | | | |

**1. Substance Use Disorder Information**

- Some substance use information is protected by the federal law 42 C.F.R. Part 2, commonly referred to as "Part 2." Your Care Partner treating your substance disorder can tell you if your substance use disorder information is protected by 42 C.F.R. Part 2.
- You can give your permission to share Part 2 substance use diagnosis or treatment information so that providers can treat you, obtain payment for services, operate their organization, and coordinate your care.
- When you give permission to share your Part 2 substance use information with Medi-Cal, your health plan, or another health care provider, they are allowed to share that information with other Care Partners for the same purposes stated in the bullet above. They may also share your information without your consent for other purposes that are allowed under federal and state law. They cannot share this information for civil, criminal, administrative, and legislative proceedings against you.
- Once your Part 2 substance use information has been used or shared, it may no longer be protected by Part 2 or protected in the same way it was before it was used or shared. Your Part 2 substance use information may instead be protected by other laws that protect your health information.
- You can get a list of the Care Partners that your Part 2 substance use disorder provider has shared your information with by contacting your substance use disorder providers.

Your Consent: I give permission for my substance use disorder treatment providers to share my past, present, and future substance use disorder information, including information that is protected by Part 2.

◯ Yes ◯ No / Does not apply to me

Behavioral Health Department
Alameda County Health

# Tracking/Sharing Consent Forms

- DHCS is developing a **Consent Management Platform (CMP).**
- Once the CMP is launched, it will allow authorized California healthcare providers to securely capture, share, and verify patient consent for behavioral health data in real time.
- As there is no electronic platform currently available for tracking and sharing consent forms, providers should share copies of the signed consent and revocation forms with the member's care team, as appropriate.
- Note: if a member declines to sign the ASCMI, document DECLINED on the form and retain the form in the member's medical record for audit purposes.

Behavioral Health Department
Alameda County Health

# ACBHD Implementation Plan for SUD Consents

# Next Steps for Providers

**New Clients:**

- Review the following forms, in this order, during the Intake process effective **August 14, 2026**:

    1. **Acknowledgement of Receipt & Consent to Services**
    2. **ACBHD Consent for TPO or PO Only (Form A)**
    3. **DHCS ASCMI Non-AB133 Form**
    4. **ACBHD Consent for Other Purposes (Form B)-** As appropriate

**Existing Clients:**

- Review the following forms by **September 30, 2026:**

    1. **ACBHD Consent for TPO or PO Only (Form A)**
    2. **DHCS ASCMI Non-AB133 Form**

Behavioral Health Department
Alameda County Health

# Required Communication

- When discussing the SUD TPO consent forms with members, providers must:
  - Clearly explain the purpose of the consent and the implications of providing or declining consent.
  - Inform members that signing the consent is voluntary and that they may revoke their consent at any time, consistent with applicable federal and state requirements.
  - Explain that the confidentiality protections under 42 CFR Part 2 continue to apply, including protections that generally prohibit the use or disclosure of SUD information in legal proceedings against the member without the member's consent or as otherwise permitted or required by law.

# Explaining Form A to Members

| ACBHD Consent for TPO or PO Only (Form A) | |
|---|---|
| What is it? | • This form is required by federal law (42 CFR Part 2) to protect your privacy. The ACBHD Consent form serves two purposes:<br>1) It allows us to share information with ACBHD so that Medi-Cal can pay for your services.<br>2) It allows everyone on your care team (your doctors, counselors) across the county to communicate about your SUD history and treatment so that your care can be coordinated.<br>• You only need to sign the form one time to allow communication amongst your care team.<br>• Your consent does not allow sharing of information with people outside of your care team, like employers, courts, or family. That requires a different consent form. |
| How does it work? | • If you check the TPO box, you are allowing us to share information with the county for billing purposes and with your care providers to coordinate your SUD services.<br>• If you check the PO box, you are only allowing us to share information with the county for billing purposes, but we won't be able to coordinate your care with your other SUD providers.<br>• Signing the form is voluntary and you can revoke it at any time by letting us know verbally or in writing. It expires as noted on the form. |
| How does it help me? | • Without your consent, we can't bill your insurer for the services you will be receiving.<br>• By allowing communication amongst your care providers, we will all be on the same page about your treatment needs and your services will be better coordinated. |

Behavioral Health Department
Alameda County Health

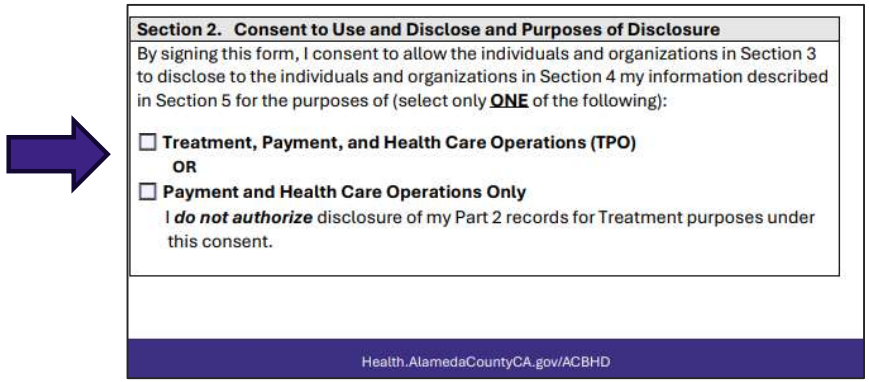
# Explaining ASCMI Non-AB133 Form to Members

| ASCMI Non-AB133 Form | |
|---|---|
| What is it? | • This form is similar to Form A, in that by signing this form, you allow us to share your SUD information with ACBHD so that Medi-Cal can pay for your SUD services.<br>• It also is similar in that when signed, it allows for coordination of care amongst your treating providers.<br>• It is different from Form A, in that it is more detailed, allowing you to check off what type of information you are comfortable sharing or not sharing.<br>• It is also different in that your care providers can share information across the State, instead of just within Alameda County.<br>• Your consent does not allow sharing of information with people outside of your care team, like employers, courts, or family. That requires a different consent form. |
| How does it work? | • You can check off yes or no to indicate what information you are comfortable sharing.<br>• You only need to sign this form once to allow sharing information amongst all your care providers within the State. It expires as noted on the form.<br>• Signing the form is voluntary and you can revoke your consent at any time by completing a Revocation form. |
| How does it help me? | • If you seek treatment outside of the County but within the State, your providers will still be able to share information to coordinate your care. |

Behavioral Health Department
Alameda County Health

# What If A Member Declines to Sign?

- To allow sharing of SUD information with a single consent AND billing ACBHD for SUD services, a member must sign **at least one** of these forms:
  - The **DHCS ASCMI Non-AB133 Form**, checking off the SUD checkbox OR
  - The **ACBHD Consent for TPO or PO Only (Form A),** checking the **TPO box**




- If a member elects not to allow sharing of SUD information but to allow the provider to bill ACBHD for SUD services, the member must sign the **ACBHD Consent for TPO or PO form**, checking the **"Payment and Health Care Operations Only" box**.

- If your agency pays for services using non-ACBHD funding sources, provides services pro-bono, or the individual pays privately, you may open in SmartCare in a private pay program for CalOMS reporting purposes.

Behavioral Health Department
Alameda County Health

# CalOMS Data Reporting Reminder

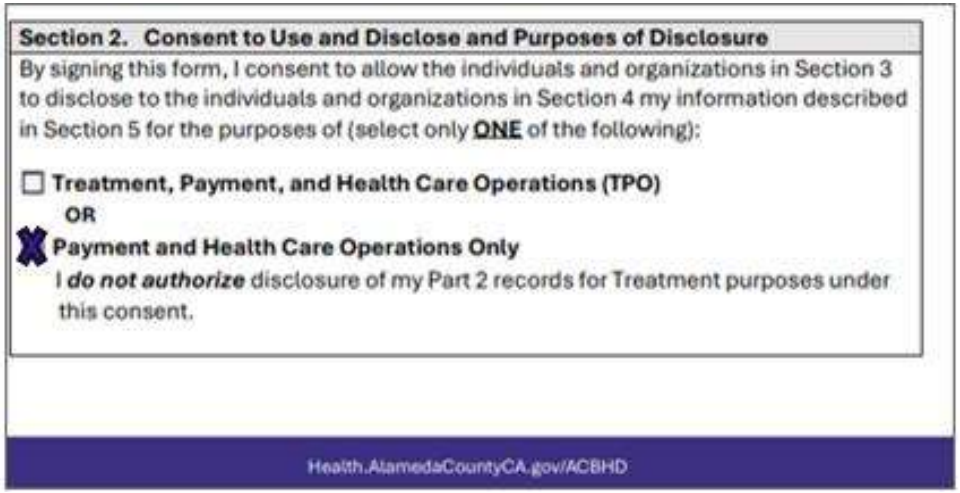
- If a member declines to sign the ACBHD SUD consent form and the ASCMI and your agency uses alternative funding or provides pro-bono services, remember the following:
  - CalOMS data reporting is required for all individuals served at your agency, including those not part of the ACBHD contract. This is a state/federal SUBG requirement.
  - ACBHD collects data for these individuals using “private pay programs” in the ACBHD billing system.
  - This data collection is allowed without a signed consent under 42 CFR § 2.53 Management audits, financial audits, and program evaluation.
  - ACBHD recently published QA Memo 2026-25: Reminder - CalOMS “Private Pay” Patient Data Collection Requirements
  - No other data for non-ACBHD or “private pay” patients should be entered into ACBHD systems.

Behavioral Health Department
Alameda County Health

# Knowledge Check

A member signs **ACBHD Consent for TPO or PO Only (Form A)** checking the box for *Payment and Health Care Operations Only*. What PHI is allowed to be shared under this consent form?

- SUD information can be shared with *county* providers for care coordination purposes but cannot be shared statewide.
- Information can be shared with ACBHD for payment and operations only.
- No information can be shared without a signed **DHCS ASCMI Non-AB133 Form**.

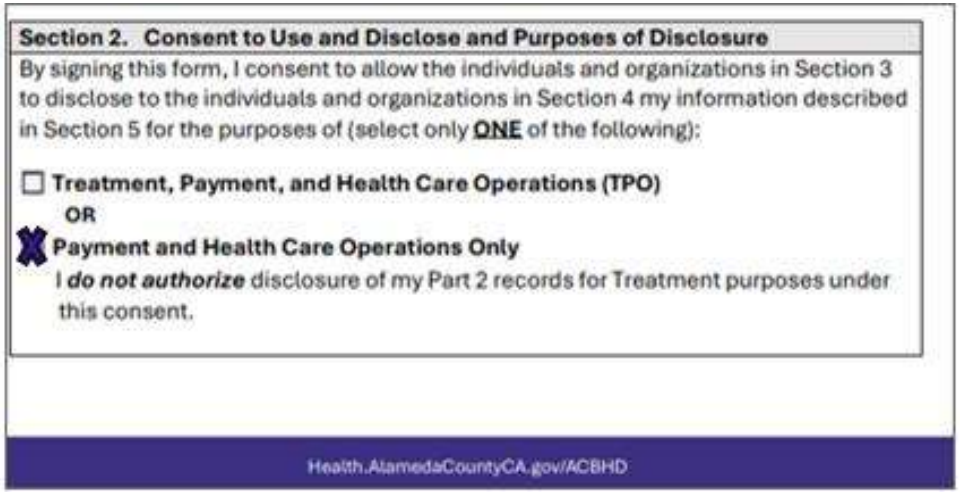



Behavioral Health Department
Alameda County Health

# Knowledge Check

A member signs **ACBHD Consent for TPO or PO Only (Form A)** checking the box for *Payment and Health Care Operations Only*. What PHI is allowed to be shared under this consent form?

- ❑ SUD information can be shared with *county* providers for care coordination purposes but cannot be shared statewide.
- ✓ Information can be shared with ACBHD for payment and operations only.
- ❑ No information can be shared without a signed **DHCS ASCMI Non-AB133 Form**.



**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.

Health.AlamedaCountyCA.gov/ACBHD

Behavioral Health Department
Alameda County Health

# Knowledge Check

A member signs **ACBHD Consent for TPO or PO Only (Form A)**, checking the TPO box but declines to sign the **ASCMI** form. What is the correct next step?

(check all that apply)

- ❑ Enroll the member
- ❑ Present the **ACBHD Consent for Other Purposes (Form B)** as a substitute for the ASCMI
- ❑ Delay enrollment until the member also signs the ASCMI form
- ❑ Indicate “No” on the ASCMI and retain the document in the medical record

Behavioral Health Department
Alameda County Health

# Knowledge Check

A member signs **ACBHD Consent for TPO or PO Only (Form A)**, checking the TPO box but declines to sign the **ASCMI** form. What is the correct next step?

(check all that apply)

- ✓ Enroll the member
- ❑ Present the **ACBHD Consent for Other Purposes (Form B)** as a substitute for the ASCMI
- ❑ Delay enrollment until the member also signs the ASCMI form
- ✓ Indicate “No” on the ASCMI and retain the document in the medical record

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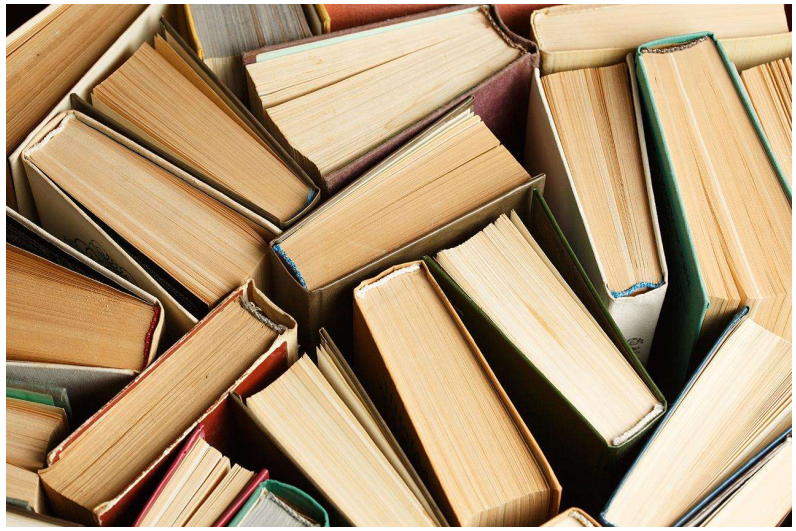
# Learn More

- ACBHD QA Manual
- 42 CFR PART 2—Confidentiality of Substance Use Disorder Patient Records
- DHCS CalAIM ASCMI Initiative
- DHCS CalAIM ASCMI FAQ
- HHS HIPAA Resources
- Focus:PHI
- QA Memo 2026-25: Reminder - CalOMS “Private Pay” Patient Data Collection Requirements



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# thank you.
# any questions?

*Thanks for your questions and attention to this presentation and your continued commitment to providing services to residents of Alameda County!*

This presentation is being recorded and will be posted on the QA Training page.

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