AUTHORIZATION FOR DISCLOSURE OF MY SUBSTANCE USE INFORMATION FOR FOR MISCELLANEOUS PURPOSES (FORM 3)

Section 1. Client Information

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

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

Section 2. Authorization to Disclose My Information

By signing this form, I authorize the individuals or organizations listed in **Section 3** to disclose my information described in **Section 4** to the individuals or organizations listed in **Section 5** for the purposes described in **Section 6**.

Section 3. Names or Types of Individuals or Organizations Disclosing My Information

I authorize the following organizations to disclose my information (check selected):

- ☐ Alameda County Behavioral Health Care Services (ACBH)
- ☐ Any past, present, or future treating substance use disorder provider within the ACBH Network (for example, my substance use counselor)
- ☐ Other (write name) _____

Section 4. My Substance Use Information to Be Disclosed

I authorize the following **substance use** information to be disclosed (check below):

- ☐ ***ALL*** information listed here
- ☐ Service history
- ☐ Assessment information/ diagnosis
- ☐ Treatment plan(s)
- ☐ Other (describe): _____
- ☐ Medication(s)
- ☐ Progress notes
- ☐ Discharge plans / summary
- ☐ Drug and lab test result(s)

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Section 5. Names of Individuals or Organizations Receiving My Information

I authorize my information to be disclosed to the following:

Name: _____ Phone number: _____

Address: _____

Name: _____ Phone number: _____

Address: _____

Name: _____ Phone number: _____

Address: _____

Section 6. Purpose(s) of Disclosure

I authorize my information to be disclosed for the following purpose(s) (describe):

_____

_____

_____

_____

Section 7. Expiration of Authorization

This authorization will expire two (2) years after the date of my signature on this form, unless I write in another date or event here: _____.

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Section 8. My Rights

- I do not have to sign this authorization form. My treatment, payment, enrollment in a health plan, and/or eligibility for benefits do not require my signing this form. However, I recognize that if I do not sign this authorization form, I may not be able to participate in certain programs that require these disclosures.
- 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 9. 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 10. 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:

_____