AUTHORIZATION FOR USE, EXCHANGE OR DISCLOSURE OF SUBSTANCE USE DISORDER PATIENT INFORMATION, SUBJECT TO 42 CFR PART 2 (County of Marin)

Completion of this document authorizes the disclosure, exchange and use of Substance Use Disorder information about you. Failure to provide all information requested may invalidate this authorization.

Name of patient: ____________________________ **Date of Birth:**________________

USE AND DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION

I hereby authorize: ____

(Specific Name(s) or General Designation(s) of Health Entity(ies), Individual(s), or Part 2 Program Permitted to Make Disclosure)

to release my Substance Use Disorder Records (SUD), subject to 42 CFR part 2 as specified below:

Substance use disorder information subject to this authorization must be explicitly described – Therefore, I specifically authorize release of the following information (check as appropriate):

- ☐ Substance Use Test Results
- ☐ Treatment Plan
- ☐ Payment/billing information
- ☐ Substance Use Disorder Diagnosis
- ☐ SUD Program Attendance
- ☐ Progress Notes
- ☐ Any Medical or Mental Health Records included in my SUD records.

Other: ____

____

To: (name(s) of individual(s)/entity(ies) authorized to receive the information):

☐ Named Individual(s) (*e.g John Smith*):_________________________________

____

Include Individual's Full Name

☐ Named Entity(ies) that have a Treating provider relationship with me: *(e.g. Marin General Hospital)*

____

Include Name of the Entity(ies)

☐ Named third-party payer (*e.g. Medi-cal*): ____________________________

Name of Client ____________________________________ Date of Birth _______________

☐ Named Entity(ies) without a treating provider relationship* (*e.g. Marin Health Gateway (HIE)*)

____

*<u>At least one</u> of the following boxes **<u>must</u>** also be checked and completed as applicable):

☐ Named individual participant *(e.g. John Smith):*

____

☐ **General designation of individual or entity or class of participants <u>with a treating provider relationship *(e.g My treatment team in the Marin Health Gateway (HIE)*)</u>: __________________

____

**If a general designation is indicated and consistent with 42 CFR Part 2, upon your request you must be provided with a list of individuals or entities to which this information has been disclosed pursuant to this general designation.

<u>PURPOSE</u>

State the specific purpose(s) of requested use or disclosure (the disclosure will be limited to that information necessary to carry out the stated purpose):

____

____

Limitations, if any:____

____

OR:

☐ The Patient has requested the disclosure (e.g. to their attorney).

<u>EXPIRATION</u>

Unless revoked sooner, this authorization expires on: __________________________

____

(*Date, event or condition*)

If no date, event or condition is provided the date of expiration will be <u>3 years from the date of this authorization.</u>

Name of Client ____________________________________ Date of Birth _______________

MY RIGHTS

- I may refuse to sign this authorization. My refusal could affect my ability to obtain services under this specific program, but efforts will be made to offer services under other programs.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, either verbally or in writing; if I do so in writing I understand that I may submit my written revocation to the following address:

  Privacy Officer
  Marin County Health and Human Services- Compliance Program
  20 North San Pedro Road
  San Rafael, CA 94903
  Email: HHSCompliance@marincounty.org

  My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization and will be offered a copy.
- Substance use disorder information may not be re-disclosed unless another authorization for such disclosure is obtained from me, or unless such disclosure is specifically required or permitted by law.

Signature: ____ **Date:**___________
(Signature of Patient/Patient Representative)

Printed name: ____

If signed by a person other than the patient, indicate relationship:
☐ parent/legal guardian of minor
☐ conservator
☐ other:_____________________________________

For Official Use Only:
Authorization/Consent revoked by: __________________________ Date: _____________
Request to revoke received by: _______________________________
Date Program was informed: ___________________