Authorization to Disclose Mental Health, SUD, HIV/AIDS Information

Name (*print first name, middle initial, and last name*):		Date of Birth (*month/day/year*):	

I authorize the following agency to disclose my information as described in this document:

Behavioral Health and Recovery Services – County of Marin	
Department of Health and Human Services 250 Bon Air Road, Unit B, Greenbrae, CA 94904 Contact: Custodian of Medical Records	Telephone: (415) 473-6835 Fax: (415)473-4113

The recipient of my information is:

Name of Agency, Individual, or Health Care Provider:		
Address:	City/State:	Zip Code:
Telephone Number:	Fax Number:	Contact Name (if known):

PURPOSE: The information may be used only for the following reason(s):

☐ For Continuity of Care
☐ For Treatment Planning/Case Management
☐ At the request of the client
☐ Other _____

INFORMATION: The following information is requested: *Important: Complete, initial, or sign and date as required.*

☐ Mental/Behavioral Health Information including health conditions, treatment, and medications.
Other: _____
Indicate date(s): From_____ To _____
☐ Alcohol or substance use disorder information, including medications, diagnosis, and lab test results.
Other: _____
Indicate date(s): From_____ To _____
☐ HIV/AIDS Information _____ (Initials) _____(Date)

RE-USE OF INFORMATION: Federal and state laws do not permit the re-disclosure of substance use disorder, mental health information, and HIV/AIDS information in most circumstances.

Notice to Recipient: If substance use disorder information has been disclosed to you from records protected by federal confidentiality rules 42 C.F.R. Part 2, the federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

If mental health records have been disclosed to you from records protected by California state law, state law prohibits you from making further disclosures unless ordered by a court.

If HIV/AIDS records have been disclosed to you from records protected by California state law, state law limits further disclosures of this information.

CONDITIONS: I understand that I do not have to sign this Authorization Form. I understand that treatment, payment, enrollment, and eligibility for benefits will not be based on my signing or refusing to sign this authorization. I understand, however, that refusal to authorize specific disclosures can affect my ability to participate in certain programs. I have a right to receive a copy of this authorization.

I further understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

RIGHT TO TAKE BACK/REVOKE AUTHORIZATION: I understand that I have the right to take back or revoke my authorization. If I take back my authorization, I must notify the BHRS in writing at the following address**:**

Behavioral Health and Recovery Services,
Department of Health and Human Services,
250 Bon Air Road, Unit B.
Greenbrae, CA 94904.
Attention: Custodian of Medical Records

My revocation will take effect upon receipt, except to the extent that others have acted in reliance on this authorization.

EXPIRATION: This authorization will go into effect immediately and will remain in effect until _____ (Date or Event). If I do not write in a date, this authorization will remain in effect for one year from the date of my signature.

Signature (*Client or Representative, as appropriate*)*:		Date (*month/day/year*) :	
**If the form is signed by someone other than the client, state the relationship to the client,* Name (*print*): _____ Relationship: _____			
Name of County Representative Who Receives this Form *(Print*):		Date (*month/day/year*):	