SOUTHERN INDIAN HEALTH COUNCIL, INC.
4058 Willows Road Alpine, CA 91901
phone (619) 445-1188
www.SIHC.org

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION [PART 2]

Reminder: Records disclosed pursuant to this authorization must be accompanied by the notice prohibiting re-disclosure.

SECTION I

I, _____, hereby
[*patient's name*]
authorize_____

_____
[*name or general designation of individual or entity making the disclosure*]

SECTION II

to disclose the following information:

- ☐ Alcohol/drug treatment information (*describe how much and what kind of information may be disclosed, including an explicit description of any substance use disorder information to be disclosed; disclosure should be as limited as possible*):

  _____

  _____

SECTION III

This disclosure shall be made to the following individual or entity (*see attached instruction sheet for information on how to accurately complete this section)*:

_____

_____

SECTION IV

The purpose of the disclosure is:

- ☐ Patient Request; Or

☐ Other (*please describe the purpose of the disclosure):*

_____

_____

[*this should be as specific as possible, so that disclosure can be limited to that information which is necessary to carry out the stated purpose*]

Unless I revoke my consent earlier, this consent will automatically expire on the following date: _____

[must be no longer than reasonably necessary to serve the purpose of this consent]

SECTION V

Acknowledgement of My Rights:

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

- I understand that I may revoke this authorization at any time, verbally or in writing, except to the extent that action has been taken in reliance on it. If I choose to revoke this authorization in writing, I will submit it to the following address: _____

- I may refuse to sign this authorization. I understand that SIHC will not condition treatment, payment, or eligibility for care on my providing this authorization.

- I understand that information disclosed pursuant to this Authorization, except for alcohol and drug abuse information as defined in 42 C.F.R. Part 2, could be re-disclosed by the recipient. Federal confidentiality rules (42 C.F.R. Part 2), and in some cases California law, prohibit the individual/entity receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained

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from me or unless such disclosure is specifically required or permitted by law.

- I understand that a separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing HIPAA.
- I have been provided a copy of this form.

SECTION VI

Date/Time of Signature: _____

Signature of Patient: _____

Signature of Individual Signing Form (if not patient): _____

Describe authority to sign on behalf of patient: _____

_____

Date Revoked: _____

Written or Verbal Revocation: _____

Staff Initials: _____

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SUBSTANCE ABUSE PROGRAM NOTICE OF PROHIBITION OF REDISCLOSURE

Date: _____

(name of patient)

Re: _____

Date of Birth: _____

This 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 information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

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INSTRUCTIONS FOR SIHC STAFF TO ENSURE PROPER COMPLETION OF THE FORM: AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION [PART 2]

1. Ensure that patient prints legibly in all fields using dark, permanent ink.

2. Ensure that any records released pursuant to the executed authorization are accompanied by the Substance Abuse Program Notice of Prohibition of Redisclosure. The notice will accompany the records, so it will go to the party identified by the patient in Section III.

3. **Section I**: Patient should print his/her name (or the name of the patient whose information is to be released), along with the name of the individual or entity who he/she is authorizing to disclose the information, e.g. "La Posta Substance Abuse Center."

4. **Section II**: The patient should check off the box and provide the requested information. Please note that the patient should clearly describe the type of drug/alcohol information to be disclosed.

5. **Section III**: Please pay close attention to completion of the following section. The information the patient should provide will depend on who the individual is authorizing disclosure to.

    a. **Disclosure to an Individual (with and without Treating Provider Relationship):** If the patient is authorizing disclosure to an individual, whether or not he or she has a treating provider relationship[1] with that individual, he/she should print the name of the individual (e.g. Dr. Jane Doe or Mr. John Doe).

    b. **Disclosure to an Entity (with Treating Provider Relationship):** If the patient is authorizing disclosure to an entity with whom he or she has a treating provider relationship, he/she should print the name of the entity (e.g. San Diego County Hospital).

[1] A "treating provider relationship" exists when a patient receives, agrees to receive, or is legally required to receive diagnosis, evaluation, treatment, or consultation, for any condition, from an individual or entity who undertakes or agrees to undertake that diagnosis, evaluation, treatment, or consultation. An in-person encounter is not required.

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c. **Disclosure to an Entity (without Treating Provider Relationship):** If the patient is authorizing disclosure to an entity with whom he or she does NOT have a treating provider relationship:

1. If the entity is a third-party payer, the patient should print the name of the entity (e.g. Medicare).

2. If the entity is NOT a third-party payer (e.g. the entity facilitates the exchange of health information, or is a research institution), then the patient should print the name of the recipient entity *and* at least one of the following:

- The name(s) of an individual participant in the recipient entity (e.g. Dr. Jane Doe);

- The name(s) of an entity participant(s) in the recipient entity that has a treating provider relationship with the patient (e.g., San Diego County Hospital); or

- A general designation of an individual or entity participant(s) or a class of participants, limited to those participants who have a treating provider relationship with the patient (e.g. "all of my past, current, and future treating providers"). [**Note:** *If a patient is using a general designation, a statement must be included on the consent form stating, "I confirm my understanding that, upon my request and consistent with this part, I must be provided with a list of entities to which my information has been disclosed pursuant to the general designation." Be sure to handwrite this statement on the consent form and have the patient initial next to it, and to also provide the patient with the list of entities.*]

6. **Section IV:** The patient should describe the purpose of the disclosure (e.g. for a disability claim, for legal use) so that SIHC can ensure it limits the disclosure to that information which is necessary to carry out the stated purpose. The patient should also print a date upon which the consent will expire.

7. **Section V:** Ensure that the patient carefully reviews all of the statements and check off the boxes, which indicates he/she has read and understands his/her rights. For this Part 2/La Posta Authorization Form, note that the patient is allowed to verbally revoke his or her consent, meaning it does not need to be in writing. If the patient does revoke his or her consent, please indicate the manner of revocation (e.g. verbal or written) at the bottom of page three.

8. **Section VI:** The patient should date and sign the form. If an individual who is not the patient is signing the form, that individual must identify legal status which authorizes him or her to sign on behalf of the patient (e.g. executor, healthcare power of attorney).

9. After the patient signs the form, provide the patient with a copy of the completed form and place the original in the patient's administrative file.

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