Merced County Care Coordination Release of Information

Patient's Information

First Name:	**Last Name:**	**Maiden Name/ Aliases:**
Date of Birth:	**Phone Number:**	**Other Phone Number:**
Duration of this Release*:	**From:**	**To:**

*** Cannot exceed one year past the date of authorization**

Explanation: Research and health care best practices show that the health of patients improves when the healthcare providers talk to each other and coordinate on their patient's health care. However, we need your permission to share and coordinate your healthcare, or the healthcare of the person for which you have legal responsibility (the Patient). Your health plan can legally exchange protected health information with providers that are paid by them on things related to your treatment, payment for your services and operations related to the health plan. These are State and Federal laws related to health care information sharing: HIPAA, 45 CFR Parts 160, 164, Subparts A&E; W&I Code 5328; 42 CFR Part 2.

If you have given permission to have the Patient's health care information shared in the Merced County Health Information Exchange, please check here: ☐

I, _____ give my permission for the following programs to disclose to and communicate with each other as necessary for the purpose of coordinating the Patient's healthcare to help improve health. Please check the providers that are involved with the Patient's health care: (Please initial beside each checked box)

- ☐ Merced County Department of Mental Health/Alcohol and Other Drug Programs
- ☐ Public Conservator/Guardian
- ☐ Central California Alliance for Health
- ☐ Merced County District Attorney
- ☐ Merced County Public Defender
- ☐ Merced County Probation Department
- ☐ Superior Court of California/Juvenile Court
- ☐ Superior Court Presiding/Assigned Judge
- ☐ Human Services Agency
- ☐ Residential Facility _____
- ☐ Parent/Guardian _____
- ☐ Primary Care Physician _____
- ☐ Psychiatrist _____
- ☐ Other Physician _____
- ☐ School Counselor _____
- ☐ Teacher _____
- ☐ Teacher _____
- ☐ Principal/Vice Principal _____
- ☐ Other Person or Agency _____
- ☐ Other Person or Agency _____
- ☐ Mercy Medical Center
- ☐ Golden Valley Health Center
- ☐ Public Health
- ☐ Family Care
- ☐ Merced Faculty Associates
- ☐ Castle Family Health Centers
- ☐ Memorial Hospital Los Baños
- ☐ CalWORKS
- ☐ NTP _____

This information includes the following:

- ☐ Assessment, Consumer Plan of Care, Treatment Plan, Progress Notes, Diagnosis, and Prognosis
- ☐ Prevention / Education information
- ☐ Medical/physical health, Mental Health, and Substance abuse treatment history including plan, details of participation, past and current medical/mental/substance abuse condition
- ☐ Periodic reports to evaluate patient progress in treatment, including Court Reports
- ☐ Results and dates of drug tests

Name: _____ Chart #: _____

- ☐ Results of psychological or vocational tests
- ☐ Current medications
- ☐ Medical diagnoses
- ☐ Health Status
- ☐ Prognosis
- ☐ Medical/psychosocial history
- ☐ Results of medical/laboratory tests
- ☐ Medical/physical health, Mental Health and Substance Abuse Rx/Pharmacy information
- ☐ HIV/AIDS Information
- ☐ Financial agreement / Documents and payment information
- ☐ Attendance Reports
- ☐ Social and academic functioning
- ☐ Access to Cumulative Files
- ☐ IEP Reports
- ☐ Grade Reports
- ☐ Disciplinary Reports
- ☐ Other _____
- ☐ Other: _____

Your medical and mental health record may contain information that you or other healthcare professionals provided to us, or authorized our agency to obtain, from other confidential sources. These authorizations allow release of information from your health plan. You may review that information to determine what, if any, information you do not want released.
Exceptions or information that I do not want released / disclosed:

Not applicable (Initial if not applicable) _____

I understand that such information cannot be released without my consent, except when required or permitted by law, and that all restrictions contained in this authorization as to the usage, transfer, or re-disclosure of such information apply to such records.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so by signing below or by submitting my written revocation to the Merced County program of origin. I understand that the revocation will not apply to the information that has already been released in response to this authorization.

I understand that authorizing the use or disclosure of the information identified above is voluntary. This document will aid and support communication between Merced County Mental Health/AOD and other County services. It will also aid and support communication with medical services providers and individuals with whom you authorize exchange of information.

Right of Consumer to Receive a Copy of Authorization:

I, (Initial) _____Do _____Do Not want a copy of this authorization.
Date of Expiration _____ or as specified: _____

_____ __(initial) **Mandated Criminal Justice Only:** There has been a formal/continuous and effective termination or revocation of my release from confinement, probation or parole or other proceedings under which I was mandated into treatment.

Name: _____ Chart #: _____

Prohibition of Usage, Transfer, or Re-disclosure of Information:

Except as required or permitted by State or Federal laws, the use of information released for purposes other than the stated purpose or re-disclosure or transfer of this information to any person or entity not named herein is prohibited. An additional written authorization must be obtained for any proposed new use of the information or its re-disclosure or transfer of such information. Authorized information may be subject to re-disclosure by the recipient and no longer protected by the privacy regulations.

_____ _____

Signature of patient / consumer, and/or legal representative Date

If signed by legal representative, authority/relationship to patient: _____

_____

I verify that: patient's/consumer's identity was confirmed, and the contents of this document were reviewed and discussed with Patient/Consumer.

_____ _____

Witness Date

Minors: By federal regulations (42 C.F.R. Part 2), drug/alcohol abuse or HIV/AIDS related information given by a minor, his/her parent, guardian or other person authorized to act on his/her behalf, the minor's signature is also required along with that of the parent, guardian or other authorized person (unless minor adjudicated incompetent). Where State law allows a minor to consent to treatment, only the minor is required to sign.

Consent to Release Information Revoked: _____ **Date:**_____ _____

Signature

Verbal notification of revocation of consent to release information _____ _____ Staff Initial _____

Date

Name: _____ Chart #: _____