AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH AND SOCIAL SERVICE INFORMATION (ADULT)

Client Name: _____ Date of Birth: _____
Client ID: _____

The County of Los Angeles ("County") operates and engages in health information exchanges to allow your information to be shared among and between County Programs and their partners to help you get resources and social services that can improve your health. A health information exchange is an electronic system that allows organizations to share information.

"County Programs" are programs that provide services to you or obtain benefits for you through the following County Departments:

- Department of Health Services (DHS)
- Department of Mental Health (DMH)
- Department of Public Health (DPH), including the Substance Abuse Prevention and Control (DPH-SAPC)
- Department of Public Social Services (DPSS)
- Justice, Care and Opportunities Department, only for re-entry services

Many types of organizations work as partners of County Programs, some as contractors or subcontractors, to provide, coordinate, or pay for these services or benefits, including:

- Health care providers
- Mental health providers
- Substance use disorder providers
- Social service providers
- Managed care plans
- Housing and assisted living providers
- Meal service providers
- Legal providers who assist you in obtaining benefits or services
- Community organizations that provide or coordinate services, including to persons involved with the justice system

These organizations may need to share your health and/or social services information to:

- See if you are eligible for services or benefits provided by County Programs or through other resources and/or for Medi-Cal enrollment and benefits
- Coordinate your health care and community supports
- Communicate with your treating providers and organizations and social service providers
- Provide you with treatment and related services
- Receive payment for services
- Conduct quality improvement, reporting, and evaluation activities
- Carry out related County Program activities

By signing my name below, I agree that my current, past, and future treating providers, non-treating providers listed in Attachment A, and County Programs may disclose my health information, records, social services information, and related data to any County health information exchange. Such data may be used and shared among and between the County Programs. I also agree that County Programs may disclose this information to my current, past, and future treating providers (including County Program subcontractors), and the managed care plans and other organizations that work with County Programs that are listed in Attachment A for the purposes described above.

- I authorize my health and social service information to be shared through any health information exchange operated by or with participation from the County.
- Information that may be shared will include:
  - My general information, such as my age and gender;
  - My medical, mental health, or substance use history;
  - My social service information (including CalFresh, Special Supplemental Nutrition Program for Women, Infants, and Children ("WIC"), General Relief, CalWorks, Cash Assistance Program for Immigrants, Medi-Cal, Homeless Management Information System/Housing Records, and other public benefits that I may apply for and/or receive); and
  - Treatment and/or services I receive.
- I understand that this Authorization will apply to data related to services I receive from County Programs (including their subcontractors).
- I understand that my information will be shared in electronic formats, including through a health information exchange, as described above. My information may also be shared in verbal and written formats.

I specifically authorize my current, past, and future treating providers and County Programs to share the following sensitive information (*check as appropriate*):

☐ Information from health care providers about my mental health diagnosis or treatment that is protected under Welfare and Institutions Code § 5328 _____ (*initial*) (excluding psychotherapy notes)

☐ Information from substance use disorder programs (includes substance use disorder diagnoses and medications, inpatient stays and outpatient visits or residential treatment, provider names and contact information, and names of the treatment programs) that is protected under 42 C.F.R. Part 2 or State law _____ (*initial*)

I may ask for a list of providers and organizations that have received my substance use disorder information by contacting my care manager.

I also authorize County Programs to share my health and social service information with the following family members or other persons so that they may assist in coordinating or paying for my care:

_____	_____
(Name)	(Relationship)
_____	_____
(Name)	(Relationship)
_____	_____
(Name)	(Relationship)

(Please continue on back of form if more room is needed.)

I understand:

- This Authorization will be valid for as long as I receive services from County Programs.
- I have the right to cancel or change this Authorization at any time. I can start this process by talking to my service provider or case/care manager. At that time, I will either cancel my Authorization or complete a new Authorization to reflect the change(s) to the sensitive information that I want to share. If I limit my information sharing, my sensitive information will not be shared from that date forward. Any sensitive information previously shared cannot be recalled. Should I elect not to share any sensitive information, certain care coordination, case management, benefits advocacy or other services may be limited, if my authorization is required by Federal law.
- State and Federal laws already allow health care organizations to share some of my health information (including sensitive information) to treat me, obtain payment, and run their operations without my consent. I understand that this Authorization does not change the information that can be shared under these laws. I also understand that my authorization is required to share my substance use disorder information, if applicable.
- When my information is shared, Federal law or California privacy law may not protect the re-sharing of my information, except for substance use disorder information that is specially protected and may not be re-shared with others.
- My ability to receive medical services, treatment, or public social services does not depend upon whether I sign this Authorization. However, if I choose not to sign this Authorization, County Programs may not be able to share data to coordinate the services I receive, and I may not be able to receive full care coordination, case management, benefits advocacy or related services.
- I have the right to:
    - Inspect or obtain a copy of my health information and social services information that is shared by this Authorization.
    - Refuse to sign this Authorization.
    - Receive a copy of this Authorization.

[*signature on following page*]

I have read this Authorization or it has been read to me. I authorize the use and sharing of my health and social services information as described above.

_____ _____

Client Signature Date

If this Authorization is signed by a person other than the client, please indicate the relationship:

_____

Relationship to Client

_____ _____

Name Date

Attachment A
Non-Treating Providers (for Payment, Benefits Advocacy, etc.)

Health Plans, Federal, State and Local Organizations

Anthem Blue Cross/Care
Health Net
Blue Shield Promise
LA Care
Molina Health Care
Kaiser Permanente
Senior Care Action Network (SCAN)
U.S. Social Security Administration Disability Determination Services
U.S. Veteran's Administration
Centers for Medicare and Medicaid Services
California Department of Health Care Services
California Department of Social Services
California Department of Developmental Services
LA Homeless Services Authority
LA County Department of Children and Family Services
LA County Department of Military and Veterans Affair
LA Cash Assistance for Immigrants Program (CAPI)

CBEST Participant Organizations (Benefits Advocacy)

Inner City Law Center
Legal Aid Foundation of Los Angeles (LAFLA)
Health Advocates
Lutheran Social Services
Los Angeles County Department of Consumer and Business Affairs
Special Services for Groups
St. Joseph's Center
Tarzana Treatment Center
The Catalyst Foundation
Volunteers of America
Watts Community Action Labor Committee (WLCAC)

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Personal Representative's Name Date

I revoke the Authorization submitted to County Programs as of _____(DATE). This Revocation does not affect any disclosures made prior to receiving this Revocation. This Revocation does not change the information that may be shared under State or federal laws without my consent.

_____ _____

Client Signature Date

If this Revocation is signed by a person other than the client, please indicate the relationship:

_____

Relationship to Client

_____ _____

Name Date