County of Sacramento Authorization to Release Health Records and Information
Sacramento County Collaborative Behavioral Health Courts

I_____understand that I may be eligible to have my criminal case brought to a Collaborative Behavioral Health Court, such as Mental Health, Mental Health Diversion, or other Sacramento County collaborative behavioral health courts. I further understand that in order for the District Attorney, my Defense Attorney and the Court to determine if I am eligible for a Collaborative Behavioral Health Court, I must allow my mental health records to be reviewed by the District Attorney, my Defense Attorney, and the Court. By initialing at the end of this paragraph, and signing below, I agree and consent to allow the Sacramento County Department of Health Services, Division of Behavioral Health Services (DHS-BHS), and Telecare to disclose my mental health records to the District Attorney, my Defense Attorney, and to the Court for the purpose of determining my eligibility.
Initials: _____

I further understand that if I am determined eligible for a Collaborative Behavioral Health Court, my records and case will be discussed by the members of the Multi-Disciplinary Team (MDT) that handles my case. The members of that team are listed below. By initialing at the end of this paragraph, and signing below, I agree and consent to have DHS-BHS disclose my records to that team for the purpose of determining the best course of treatment for me and for the resolution of my criminal case. I further agree and consent to allow the members of the MDT to review my records and to discuss my case with other members of the MDT.
Initials:_____

I further understand that Collaborative Behavioral Health Courts are open Courts and that members of the public may and do attend open court sessions. Visitors to the Court may also observe MDT meetings. By initialing at the end of this paragraph, and signing below, I acknowledge and consent to allow my MDT meetings to be observed by visitors to the Court. I further acknowledged and consent to my case being discussed in open court with the understanding that portions of my mental health and alcohol and other drug record may be discussed before the Court in an open and public session. **Initials**:_____

I further understand that a finding that I suffer from a mental disorder, any progress reports concerning my treatment, or any other records related to a mental disorder that were created as a result of participation in, or completion of, diversion or eligibility for diversion may not be used in any other proceeding without my consent unless the information is relevant evidence that is admissible under the standards described in paragraph (2) of subdivision (f) of Section 28 of Article I of California Constitution. I further understand that signing this does not equate to my consent for information to be used in any other proceeding.
Initials:_____

Lastly, I understand that upon acceptance into the court process, my mental health provider will request and review other releases of information with me to support their participation in collaboration and coordination of care with court partners on my behalf.
Initials:_____

For the purpose of locating the correct records please provide the following information;

CLIENT/PARTICIPANT INFORMATION		
Last Name:	First Name:	M.I.:
SSN (Last 4 Digits) OR ID:	Date of Birth:	Record #:
Address:	City/State/Zip Code:	

Check each type of confidential information to be released *(Clearly mark the information that may be disclosed. Check all that apply)*:

☐ Entire Record (Excludes HIV, Mental Health & Alcohol / Drug information.)

☐ Include HIV or AIDS Information ☐ Billing or Payment Information ☐ Lab Tests

☐ Include Alcohol / Drug Information ☐ Attendance Only Records ☐ Social History

☐ Include Mental Health Information ☐ Discharge Summary ☐ Medication

☐ Treatment / Personal Services Plan ☐ Consultation Reports/Physician Order

☐ Psychiatric/Psychological Assessment/Testing Results

☐ Other (please describe): _____

Note: Records or information relating to mental health, or substance use disorder, or results of HIV antibody tests are specifically protected, and will not be disclosed unless you sign below:

☐ Mental Health Records **Signature:** _____

☐ Substance Use Disorder Records **Signature:** _____

☐ HIV Antibody Test Results **Signature:** _____

I understand that the above identified and selected confidential information will be discussed in a Multi-Disciplinary Team (MDT) to the following team members:

☐ Mental Health Provider: (Agency and Provider name):

☐ Sacramento County Mental Health Plan Contract Providers

☐ Sacramento County Substance Use Prevention and Treatment Providers

☐ Sacramento County Division of Behavioral Health Services

☐ Representing Sacramento County Public Defender or Representing Attorney

☐ Sacramento County Public Defender's Office Social Services Representative

☐ Sacramento County Superior Court

☐ Court-Assigned Sacramento County Probation Officer

☐ Out-of-County Department:

☐ Other:

☐ Other:

Records are to be released to my Defense Attorney to be shared in accordance with the eligibility process for Mental Health Diversion and Mental Health Collaborative Court(s). I understand that this means my attorney may share these records with the District Attorney and the Court. I agree and consent to the further release of my records to members of my assigned MDT if I am determined eligible for Mental Health Diversion or a Collaborative Court Program.

Authorization will expire on (mm/dd/yyyy)**:** _____ *(Authorization will expire, at maximum, one year from date of signature)*

Important Note

Special kinds of health information have specific laws and rules that have to be followed before that information can be disclosed.

General Medical Records: Re-disclosure of these records is not allowed unless another authorization is obtained from you, or unless such disclosure is specifically required or permitted by federal or state law.

HIV, Alcohol and Drug, and Mental Health Treatment: These records are protected under federal or state law and cannot be disclosed without your written authorization unless otherwise provided. All HIV test information released must be labeled with a statement that: "This information may not be disclosed to anyone without the specific written authorization of the individual." I understand that my representative or I may revoke this authorization to obtain, use and disclose my information at any time in writing. I understand this change will not affect information that has already been shared. I understand that this authorization is voluntary; that my health information may be protected under federal or state confidentiality laws. I understand that these federal or state laws may not apply to the person or organization receiving the information being shared. I understand that I may choose not to sign this authorization, and this will not affect my ability to obtain treatment or payment or my current eligibility for health care benefits. However, if this information is necessary to determine if I am eligible to enroll in the Sacramento County Health program, I may not be able to show I qualify for these services. **(If applicable)** I understand that County of Sacramento has been asked to provide a health care service to me (such as a test or evaluation) only for the purpose of being able to provide that information to someone else, and if I choose not to authorize the disclosure of that information to the other person, then County of Sacramento may not provide that health care service to me.

I understand that I have a right to a copy of this authorization.

Full Legal Signature or Mark of Individual	Date
Full Legal Signature of Representative Relationship	Date
Signature of County Representative and/or representing Attorney	Date
Printed Name of County Representative and/or representing Attorney	

If the signer is a guardian or legal custodian of an adult, minor, emancipated minor or a representative of a deceased patient and is authorized by state law to act on behalf of the individual in making decisions about health care, a copy of the legal authority (guardianship or custody order) must be attached to this form. If the signer is a personal representative that does not have the legal authority, the client must provide documentation in writing appointing this person as a representative and this documentation must be attached.

Authorization to Release Health Records and Information
INSTRUCTIONS

VERIFICATION: We are required to verify you have the authority to sign this form. You will need to provide picture identification, like a California state ID or a California driver's license. (See County HIPAA Privacy Rule Policy and Procedures for other acceptable forms of identification). You are required to attach a copy of the picture identification or present it in person.

VERIFICATION for Personal Representative: If the signer is a guardian or legal custodian of an adult, minor, emancipated minor or a representative of a deceased patient and is authorized by state law to act on behalf of the individual in making decisions about health care, a copy of the legal authority (guardianship or custody order) must be attached to this form. If the signer is a personal representative that does not have the legal authority, the client must provide documentation in writing appointing this person as a representative and this documentation must be attached.

ABOUT THE FORM: This authorization is a **Voluntary Form**. Be sure the individual understands it before signing.

EXPIRATION DATE: The expiration date cannot exceed one year from the client's signature date. In addition, if this release is for an event, please enter the event expiration date.

RIGHT TO REVOKE: The individual has a right to revoke this form. When an individual revokes written authorization to disclose information, the County of Sacramento must boldly mark the authorization form "revoked" and include the date and signature of the requesting individual.

COPY TO THE INDIVIDUAL: We must provide the individual with a copy of the signed authorization.

VALID AUTHORIZATION: THIS AUTHORIZATION IS NOT VALID IF:

- The expiration date has passed, or the one-time event is known by the covered entity to have occurred.

- The authorization has not been filled out completely, with respect to any applicable elements described below:

  -A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.

  -The name or other specific identification of the person authorized to make the requested use or disclosure.

  -A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.

  -An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. The statement "end of the research study," "none," or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository.

  -Signature of the individual and date. If a personal representative of the individual signs the authorization, a description of such representative's authority to act for the individual must also be provided.