County of Sacramento

Authorization To Release Information To Multidisciplinary Team (MDT)

NAME/ADDRESS/PHONE OF COUNTY PROGRAM:

Adult Correctional Health - Medical Records
7001A East Pkwy #700, Sacramento, CA 95823
Ph: 916-875-9918 | Fax: 916-854-8983

Client Name (First, Middle, Last): *Print Neatly*	
Date of Birth:	**Record #:**
Address:	
City/State/Zip Code:	
Phone #: ( )	
Other contact info:	

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

☐ Mental Health records	**Signature**:
☐ Substance Use Disorder records	**Signature**:
☐ HIV antibody test results	**Signature**:

INFORMATION TO BE RELEASED (Clearly describe the information that may be disclosed.)

<u>Check all that apply</u>

☐ All Medical Records *(<u>Except</u> Mental Health, Substance Use Disorder or HIV <u>unless indicated in section above</u>)*

☐ Lab Tests
☐ Medication
☐ Treatment/Personal Service Plan
☐ Discharge Summary
☐ Social History
☐ Attendance Only Records
☐ Consultation Reports/Physician Order
☐ Progress Reports/Notes
☐ Psychiatric/Psychological Assessment/Testing Results
☐ Billing or Payment Information

☐ Records from a specific visit or hospitalization (Enter date and location): _____

☐ Other (**<u>Must describe--add sufficient detail)</u>**):

PURPOSE: The information disclosed to the MDT may only be used for the following purpose(s):

I understand that my confidential information indicated above will be discussed or disclosed to the following MDT team members (<u>check only those that apply</u>):

Team Members (list by name or class/role and entity):

☐ _____ ☐ _____
☐ _____ ☐ _____
☐ _____ ☐ _____
☐ _____ ☐ _____

EXPIRATION: This Authorization will expire on ____/____/_____date. (mm/dd/yyyy) *(Must be no more than one year from the date of signature.)*

- **REVOCATION:** You or your personal representative can revoke this authorization at any time upon written request. Revocation will take effect upon receipt, except to the extent that others have acted upon this authorization prior to receipt of the revocation.
- **REDISCLOSURE:** Re-disclosure of these records is not allowed unless another authorization is obtained from you, <u>or</u> such disclosure is specifically required or permitted by federal or state law.
- **You have the right to receive a signed copy of this authorization.**

		/ /
Client's Signature	**Printed Name**	**Date**
		/ /
Personal Representative's Signature	**Printed Name**	**Date**

STAFF PERSON WHO VERIFIED IDENTITY OF THE ABOVE (Print First & Last Name):

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 client 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 patient must provide documentation in writing appointing this person as a representative and this documentation must be attached.

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, Substance Use Disorder, 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 any one without the specific written authorization of the individual."

Information in Substance Use Disorder records is protected by federal confidentiality rules (*42 CFR Part 2*). The federal rules prohibit redisclosure 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. 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 by law.

This authorization is voluntary. The client's health information may be protected under federal or state confidentiality laws. These federal or state laws may not apply to the person or organization receiving the information being shared. The client may choose not to sign this authorization and this will not affect their ability to obtain treatment or payment or my current eligibility for health care benefits. However, if this information is necessary to determine if client is eligible to enroll in the Sacramento County Health program, the client may not be able to show they qualify for these services.

(If applicable) Client understands that County of Sacramento has been asked to provide a health care service (such as a test or evaluation) only for the purpose of being able to provide that information to someone else, and if client chooses not to authorize the disclosure of that information to the other person, then County of Sacramento may not provide that health care service to the client.

VALID AUTHORIZATION: THIS AUTHORIZATION IS NOT VALID IF:
The authorization is missing the 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.
- The name or other specific identification of the person(s) or class of persons to whom the covered entity may 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.
- A specific expiration date not to exceed one year from the client's signature.
- Signature of the client or client's personal representative and date.

INSTRUCTIONS
for the Multidisciplinary Team Authorization Form 2099c

If a client is NOT part of a designated MDT, use the HIPAA Form 2099 Authorization form.

VERIFICATION: We are required to verify and confirm the client's identity with 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). Attach a copy of the picture identification.

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.

TEAM MEMBERS: Must identify the team member(s)'s name or class/role and entity. For example, Sacramento County Probation Officer (not Probation Department), Sacramento County CPS Worker (not Child Protective Services), etc. If a new member class/role or name needs to be added, a new authorization must be obtained.

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:

1. The expiration date has passed or the one-time event is known by the covered entity to have occurred.
2. 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.