Alameda County Behavioral Health Care Services (BHCS)
2000 Embarcadero Cove, Suite 400 Oakland, California 94606

AUTHORIZATION TO DISCLOSE MY INDIVIDUALLY IDENTIFIABLE SUD INFORMATION – BHCS SUD PROGRAMS EMERGENCY CONTACT

PATIENT INFORMATION

Last Name **First Name** **Middle Initial**

Date of Birth **Social Security No.** **Home Phone** **Work Phone** **Extension**

Street Address **City** **State** **Zip Code**

I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE SUBSTANCE USE DISORDER (SUD) INFORMATION BE RELEASED FROM:

- **BHCS County Staff**
- **BHCS SUD Provider Network (collectively SPN)***

(☐) Check box and complete below to add a treatment provider outside BHCS/SPN network:

Non-SPN Treatment Provider **Phone Number** **Extension**

Street Address **City** **State** **Zip Code**

I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE SUD INFORMATION BE RELEASED TO AND USED BY:

Name of Emergency Contact #1 **Phone Number** **Extension**

Street Address **City** **State** **Zip Code**

Name of Emergency Contact #2 **Phone Number** **Extension**

Street Address **City** **State** **Zip Code**

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I understand that my SUD treatment, diagnosis, and referral; payment; enrollment; case management; care coordination; medication management; and/or eligibility for benefits are conditioned on completing this authorization.

EXPIRATION:

This Authorization expires twelve (12) months from last date of SUD services by BHCS and/or SPN.

Disclosure Purpose	Amount and Kind
• Lawful holders of my protected SUD information may contact my emergency contact(s) in the event of an emergency, and thereby disclose that I am a patient being served in this SUD program.	• Limited to that information which is necessary to carry out the Disclosure Purpose • I permit lawful holders to re-disclose my protected SUD information subject to this authorization and 42 CFR part 2 • Other: _____

_____	_____	_____
Signature of Patient	**Print/Type Name**	**Date**

_____	_____	(☐) Parent	_____
Signature of Parent or Guardian	**Print/Type Name**	(☐) Guardian	**Date**

REVOCATION AND REQUEST: I understand that I have a right to revoke this authorization at any time unless action has been taken in response to or in reliance on this authorization. I understand to contact a BHCS Health Information representative in order to revoke the authorization granted to BHCS. I further understand that I should provide a separate revocation to any other person or entity that I have authorized to disclose, receive, or otherwise use my individually identifiably SUD information above in order to revoke the authorization granted to that person or entity.

* SPN includes past, current, and future network providers. A directory of current network providers participating in the SPN is available at http://www.acbhcs.org/SUD/docs/SUD_providers_dirctory.pdf. I understand that I have a right to request a list of entities to which my patient identifying information has been disclosed pursuant to a general designation under this authorization and applicable regulations. I further understand that such a request must be in writing and limited to disclosures made within the past two years.

PROHIBITION ON RE-DISCLOSURE OF PROTECTED SUD INFORMATION: 42 CFR part 2 prohibits unauthorized disclosure of these records.