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

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)*
- Cal. Dept. of Health Care Services
- Medi-Cal, Medicaid, and/or Medicare
- The following insurance company or payer:

(☐) 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:

- BHCS County Staff; • SPN*
- Cal. Dept. of Health Care Services
- Non- SPN Treatment Provider named above
- Medi-Cal, Medicaid, and/or Medicare
- The following insurance company or payer:

(☐) For Other, check box and complete below:

Name of Provider/Clinic/Hospital | **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
• Treatment, Diagnosis, and Referral • Payment • Case management, care coordination, and medication management • Eligibility, coverage, and coordination of public assistance, benefits, & services • Health care operations activities • Research, evaluation, audit	• 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.