



**COUNTY OF SAN LUIS OBISPO**  
**HEALTH AGENCY**  
**BEHAVIORAL HEALTH DEPARTMENT**  
**Michael Hill**, *Health Agency Director*  
**Anne Robin**, *LMFT Behavioral Health Director*

## **Behavioral Health Records Request Procedure**

All requests for protected health information (PHI) require the individual's written consent. Each request for behavioral health records must include a completed Release of Information signed by the individual.

Send all behavioral health record requests to:  
Central Health Information  
Fax: (805) 781-4271  
Mail: 2178 Johnson Ave San Luis Obispo, CA 93401  
Phone: (805) 781-1403

**CONFIDENTIAL PATIENT INFORMATION – NOT TO BE FORWARDED**

This information has been disclosed to you from records that are **confidential** and protected by **state confidentiality law** that protects mental health records (See California Welfare and Institutions Code Section 5328). Information subject to release in accordance with Federal Privacy Act of 1974 (Public Law 93-597). This information has been disclosed to you from records protected by **Federal confidentiality rules** (42 CFR, Part 2, Section 2.32). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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 criminally investigate or prosecute any alcohol or drug abuse patient.

Total pages included: \_\_\_\_\_

*The Health Agency complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex or any other protected class*

**County of San Luis Obispo Health Agency**

2180 Johnson Avenue | San Luis Obispo, CA 93401 | (P) 805-781-4719 | (F) 805-781-1273  
slobehavioralhealth.org | slocounty.ca.gov

**San Luis Obispo County Behavioral Health Department  
AUTHORIZATION TO USE AND-OR DISCLOSE  
PROTECTED HEALTH INFORMATION**

Last Name

First Name

Address

City/State/Zip

Home Phone

DOB

SSN, last 4 digits:

**San Luis Obispo County Behavioral Health Department is authorized to:**

Receive/Obtain information from:  Yes  No

Disclose information to:  Yes  No

Exchange information between:

SLO Drug and Alcohol Services  Yes  No  N/A

SLO Mental Health Services  Yes  No  N/A

SLO Public Health Services  Yes  No  N/A

**Name of Party to Receive and-or Disclose Information:**

Name:

Address:

City/State/Zip

Phone:

Fax:

Relationship to Client:

**Description of information to disclose:**

All my substances use program records

All my mental health records

All my public health records

Current Diagnosis Review

Current Psychiatric Evaluation

Discharge Summary

Current Intake Assessment

Medication History

Current Treatment Plan

Treatment Summary

Nursing Assessment

Progress Report

Laboratory Results

Other (Specify)

Level of Care and Services Recommended

Attendance Record/Letter

Payment Record

Drug Testing Results

**I specifically authorize the use and-or disclosure of the following health information:**

Alcohol and/or Drug Abuse Treatment Program Records (Required to authorize exchange of information between SLO DAS and SLO MHS)  Yes  No

HIV/AIDS Testing, Diagnosis and/or Treatment Information  Yes  No

Purpose of disclosure:

Is this limited to a single disclosure?  Yes  No

If yes, explain:

If no, this authorization will remain in effect from the date of this authorization until:

**I understand that:**

1. I understand that I have the right to receive a copy of this authorization.
2. This authorization includes written, electronic and/or verbal disclosure.
3. A copy of this authorization is as valid as an original.
4. I have the right to revoke this authorization by sending a signed notice stopping this authorization:  
SLO Health Agency Medical Records: 2178 Johnson Ave., San Luis Obispo, CA 93401  
or via e-mail at [privacy@co.slo.ca.us](mailto:privacy@co.slo.ca.us); or call (855) 326-9623
5. This authorization will cease on the date my valid revocation request is received. I also understand that any information released prior to revoking this authorization is not a breach of my confidentiality.
6. A form known as The Notice of Privacy Practices which is given to clients who receive medical services, provides instructions should I chose to revoke my authorization and includes limitations on my revocation. I can access this notice on the internet at:  
<http://www.slocounty.ca.gov/health.htm>
7. Treatment cannot be denied to me if I refuse to sign this authorization. However, outside agencies that require protected health information to provide various services for me may not be able to do so.
8. The information will only be used as described in this authorization. If the organization or person I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
9. Records and copies obtained relating to outpatient psychotherapy shall be returned or destroyed at the expiration date of this authorization except those obtained for treatment and diagnosis purposes.
10. I understand that alcohol and/or drug treatment records are protected under the federal regulations governing confidentiality of alcohol and drug abuse patient records. These include; 42 C.F.R. Part 2, the Health Insurance Portability and Accountability Act of 1996 (HIPPA), and 45 C.F.R. Pts 160 and 164. Records cannot be re-disclose without my written consent unless otherwise provided for in the regulations.

I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use/or disclosure of my health information. By my signature below, I hereby knowingly and voluntarily authorize San Luis Obispo County Behavioral Health Department to use and/or disclose my health

information in the manner described above.

A minor client's signature (12 - 17) is required to disclose information concerning care for mental health conditions and/or alcohol and drug abuse issues.

Form HIPAUTHDIS; Version 2.09; 03/18/2021

### Signatures

Signature	Signature Line Heading	Name	Date	Time
	C Client			
	S Staff Witness			
	S LPHA			

**San Luis Obispo County Behavioral Health Department  
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