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

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; 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			

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