Yolo County Specialty Court Programs

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, Date of birth _____ authorize Yolo County Health and Human Services **to use, disclose and exchange** with each other my mental health information from my mental health services and substance use disorder information to the following specialty court partners for the purpose of collaboration and coordination of my care (and anything else that might be pertinent).

☐ I specifically authorize release of the following information (check as appropriate):

☐ Mental health treatment information (excluding psychotherapy notes)

☐ HIV test results

☐ Substance use disorder treatment information

Substance use disorder information subject to this authorization includes diagnosis, history of use information for purposes of current treatment planning and collaboration with treatment team

(Check all that apply:)

☐CommuniCare Health Centers of Yolo County
☐Yolo County Health and Human Services Agency
☐Yolo County Superior Court
☐Yolo County District Attorney Office
☐Yolo County Public Defender
☐Yolo County Conflict Counsel
☐Yolo County Office of Private Counsel
☐Yolo County Probation
☐Yolo County Sheriff's Office
☐ Yolo County Monroe Detention Center
☐Well Path Yolo County jail services

The purpose of the disclosure is to inform the persons representing the agencies above of my attendance and progress in treatment.

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

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I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows, and not later than one year from the date of signature:

_____

(date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent)

I have been provided a copy of this form.

Dated: _____

Signature:_____

Signature of person signing form if not patient and describe authority to sign on behalf of patient: _____

Date revoked:_____

Staff initials:_____