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Public Health



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September 10, 2012

SAPC BULLETIN NO. #12-03

TO: Executive Directors
Assembly Bill 109 Providers

FROM: John Viernes, Jr., Director 
Substance Abuse Prevention and Control

SUBJECT: **AUTHORIZATION FOR THE LIMITED DISCLOSURE OF SUBSTANCE ABUSE PREVENTION AND TREATMENT INFORMATION**

The purpose of this bulletin is to provide you with the Authorization for the Limited Disclosure of Substance Abuse Prevention and Treatment Information Form to be utilized under Los Angeles County's Public Safety Realignment Act, Assembly Bill (AB) 109 program. The attached form is to be used as authorization to assist in patient's compliance, if required by law, with the Post-release Community Supervision Program, or the Mandatory Supervision Program per Penal Code 1170(h)(5), as created by AB 109.

This authorization form, finalized and approved by the Los Angeles County Counsel, would allow law enforcement personnel to conduct treatment compliance checks for AB 109 Post-release Supervised Persons (PSPs) while adhering to patient privacy and confidentiality laws, and is limited to verification of enrollment and physical confirmation of the PSP in treatment.

This authorization form is to be utilized by your agency should law enforcement require compliance checks of PSPs in treatment. In addition, your agency is to retain a copy of the PSPs signed authorization form in the patient's personnel record. If you have any questions or need additional information, please contact your assigned Contract Program Auditor or the SAPC Helpline at (888) 742-7900, Monday to Friday, from 8:00 AM to 5:00 PM.

JV:js
P:\Assign12-13\AB109\ComplianceConsentFormBulletin

Attachment

AUTHORIZATION FOR THE LIMITED DISCLOSURE OF SUBSTANCE ABUSE PREVENTION AND TREATMENT INFORMATION¹

This authorization is to be used only to assist in the patient's compliance, if required by law, with the Post-Release Community Supervision Program, or the Mandatory Supervision Program per Penal Code §1170(h)(5), as created by 2011 California Assembly Bill 109.

Your identifiable health information can be disclosed only if this authorization is completely filled out, dated, and signed.

I _____ hereby authorize _____ (the alcohol/drug/substance abuse treatment facility that is providing me treatment) to disclose protected health information, only upon the specific request of law enforcement personnel, and limited only to the following disclosures:

- 1) Whether I am, or am not, currently being treated at the specific substance abuse treatment facility from which this information is being requested.
- 2) Whether I am, or am not, a resident of the specific substance abuse treatment facility from which this information is being requested.

Law enforcement personnel are defined as police officers employed by the Los Angeles Police Department, Deputy Sheriffs from the Los Angeles County Sheriff's Department, Deputy Probation Officers from the Los Angeles County Probation Department, and police officers of any other official police department of an incorporated municipality located within the County of Los Angeles.

PURPOSE

This information is to be disclosed to the aforementioned law enforcement personnel for the sole purpose of identifying the status of my residency, and the status of my participation, in the program including my dates of admission and discharge, as applicable.

I and my successors, descendants, or assigns hereby hold the disclosing substance abuse treatment facility, its employees, my physician(s), and any other person participating in my care and their successors and assigns harmless from and against

¹ CFR Title 42 §2.35(a) and Health Insurance Portability and Accountability Act (HIPPA) Privacy Regulations, 45 C.F.R. Section 164.508(b)(2) and 164.501; Cal. Civil. Code Section 56.11

any claims for injury or compensation resulting from the disclosure of information authorized by this agreement.

EXPIRATION

I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows;

If my participation in alcohol/drug/substance abuse treatment is mandatory, then this Authorization expires upon the formal and effective termination or revocation of my release from confinement, probation, parole, or other proceeding under which I was mandated into treatment.

If my participation in alcohol/drug/substance abuse treatment is voluntary, then this Authorization also expires upon the formal and effective termination or revocation of my release from confinement, probation, parole, or other judicially imposed proceeding.

Upon expiration of this Authorization, the disclosing facility will not permit further release of any similar such information, but will not be able to call back any information already released.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to Receive a Copy of this Authorization:

I understand that if I agree to sign this Authorization, I have a right to receive a copy of this authorization. A photocopy or facsimile of this authorization may be used in place of the original.

I understand that:

-I authorize the use or disclosure of my identifiable health information as described above for the purposes listed. I understand that this authorization is voluntary (45 C.F.R. Section 164.508(c)(2)(i).

- I have a right to revoke this authorization by sending a signed notice stopping this authorization to the Substance Abuse Program where I received treatment. Such revocation will stop further release of my identifiable health information on the date my valid revocation is received.

- I am signing this authorization voluntarily and that my treatment will not be affected if I do not sign this authorization.

-Under California law, the recipient of the identifiable health information under the authorization is prohibited from re-disclosing the information, except with a written authorization or as specifically required or permitted by law.

-I understand law enforcement is not considered a health care provider or health plan, and understand as such, the released information may no longer be protected by federal privacy or confidentiality regulations.

AUTHORIZATION

I have had an opportunity to review and understand the content of this authorization form. I have also had an opportunity to request a copy of this form be given to me after I have signed it. By signing this authorization, I confirm that this Authorization accurately reflects my wishes

Signed: _____

Date: _____

REVOCATION OF AUTHORIZATION FORM

Last Name First Date of Birth (Mo/D/Yr)

I wish to revoke my Authorization:

Signature

DATE: _____ / _____ / _____
Month Day Year