AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH AND SOCIAL SERVICE INFORMATION (ADULT)

CLIENT NAME	CLIENT ID	DATE OF BIRTH:

The County of Los Angeles ("County") operates programs that provide services to you or obtain benefits for you through the following County Departments ("County Programs"):

- Department of Health Services (DHS)
- Department of Mental Health (DMH)
- Department of Public Health (DPH), including the Substance Abuse Prevention and Control (DPH-SAPC)
- Department of Public Social Services (DPSS)
- Justice, Care and Opportunities Department (JCOD)
- Department of Homeless Services and Housing (HSH) (effective 1/1/2026)

Many types of organizations work as partners of County Programs, some as contractors or subcontractors, to provide, coordinate, or pay for these services or benefits, including:

- Health care providers
- Mental health providers
- Substance use disorder providers
- Social service providers
- Managed care plans
- Housing and assisted living providers
- Meal service providers
- Legal providers who assist you in obtaining benefits or services
- Community organizations that provide or coordinate services, including to persons involved with the justice system

County Programs and their partners may need to use and share your health and/or social services information to:

- See if you are eligible for services or benefits provided by County Programs or through other resources and/or for Medi-Cal enrollment and benefits
- Coordinate your health care and community supports
- Communicate with your treating providers and organizations and social service providers
- Provide you with treatment and related services
- Receive payment for services
- Conduct quality improvement, reporting, and evaluation activities
- Carry out related County Program activities

PATIENT HIM LABEL
NAME
DOB
FIN#
MR#
SEX on ID

AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH AND SOCIAL SERVICE INFORMATION (ADULT)

By signing my name below, I agree that my treating providers, health plans and third-party payers, and other organizations that work with County Programs that are listed in Attachment A may disclose my health information, records, social services information, and related data to the County Programs. Such data may be used and shared among and between the County Programs for future treatment, payment, and health care operations and any of the purposes listed above, as permitted by the Health Insurance Portability and Accountability Act (HIPAA) and the federal rules about substance use disorder data ("Part 2 Rules"), or by this Authorization. I also agree that County Programs may disclose this information to my treating providers (including County Program subcontractors), health plans and third-party payers, and other organizations that work with County Programs that are listed in Attachment A for future treatment, payment, and health care operations and any of the purposes described above as permitted by HIPAA and the Part 2 Rules, or by this Authorization.

- I authorize my health and social service information to be disclosed to and shared by County Programs.
- Information that may be shared will include:
  - My general information, such as my age and sex;
  - My medical, mental health, or substance use history;
  - My social service information (including CalFresh, Special Supplemental Nutrition Program for Women, Infants, and Children ("WIC"), General Relief, CalWorks, Cash Assistance Program for Immigrants, Medi-Cal, Homeless Management Information System/Housing Records, and other public benefits that I may apply for and/or receive); and
  - Treatment and/or services I receive.
- I understand that this Authorization will apply to data related to services I receive from County Programs (including their subcontractors).
- I understand that my information will be shared in electronic formats, including through a health information exchange. My information may also be shared in verbal and written formats.

I specifically authorize my treating providers and County Programs to share the following sensitive information (*check as appropriate*):

☐ Information from health care providers about my mental health diagnosis or treatment that is protected under Welfare and Institutions Code § 5328 (excluding psychotherapy notes) _________ (*initial*)

☐ Information from substance use disorder programs (includes substance use disorder diagnoses and medications, inpatient stays and outpatient visits or residential treatment, provider names and contact information, and names of the treatment programs) that is protected under 42 C.F.R. Part 2 and/or State law (excluding substance use disorder counseling notes) _________ (*initial*)

☐ Information about my HIV/AIDS test results _________ (*initial*)

I may ask for a list of providers and organizations that have received my substance use disorder information by contacting my care manager.

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This authorization only permits the sharing of information for the purposes and to the parties described in this form. This authorization does not apply to psychotherapy notes or substance use disorder counseling notes. Treating providers must obtain a separate authorization to disclose these types of information. This authorization does not permit disclosures of substance use disorder information, Reproductive Health information, or medical information on abortion/abortion-related services for civil, criminal, administrative, or legislative proceedings against the patient. Also, this authorization does not permit sharing of medical information on abortion / abortion-related services with persons from out-of-state or federal law enforcement agencies.

I also authorize County Programs to share my health and social service information (except for psychotherapy notes or substance use disorder counseling notes, HIV test results, and abortion-related information) with the following family members or other persons so that they may assist in coordinating or paying for my care:

(Name) (Relationship)

______________________________ ______________________

(Name) (Relationship)

______________________________ ______________________

(Name) (Relationship)

______________________________ ______________________

(Please continue on back of form if more room is needed.)

I understand:

- This Authorization will be valid for as long as I receive services from County Programs.
- I have the right to cancel or change this Authorization at any time. I can start this process by talking to my service provider or case/care manager. At that time, I will either cancel my Authorization or complete a new Authorization to reflect the change(s) to the sensitive information that I want to share. If I limit my information sharing, my sensitive information will not be shared from that date forward. Any sensitive information previously shared cannot be recalled. Should I choose not to share any sensitive information, certain care coordination, case management, benefits advocacy, or other services may be limited, if my authorization is required by Federal law.
- State and Federal laws already allow health care organizations to share some of my health information (including sensitive information) to treat me, obtain payment, and run their operations without my consent. I understand that this Authorization does not change the information that can be shared under these laws. I also understand that my authorization is required to share my substance use disorder information, if applicable.

PATIENT HIM LABEL

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- When my information is shared, Federal law or California privacy law may not protect the re-sharing of my information.
- My ability to receive medical services, treatment, or public social services does not depend upon whether I sign this Authorization. However, if I choose not to sign this Authorization, County Programs may not be able to share data to coordinate the services I receive, and I may not be able to receive full care coordination, case management, benefits advocacy, or related services.
- I have the right to:
  - Inspect or obtain a copy of my health information and social services information that is shared by this Authorization.
  - Refuse to sign this Authorization.
  - Receive a copy of this Authorization.

I have read this Authorization or it has been read to me. I authorize the use and sharing of my health and social services information as described above.

____

CLIENT NAME

____

CLIENT OR RESPONSIBLE PERSON SIGNATURE DATE

If this Authorization is signed by a person other than the client, please indicate the relationship:

____

NAME RELATIONSHIP TO CLIENT

PATIENT HIM LABEL

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Attachment A
Organizations that Work with County Programs (for Payment, Benefits Advocacy, etc.)

Health Plans, Federal, State and Local Organizations
Anthem Blue Cross/Care
Health Net
Blue Shield Promise
LA Care
Molina Health Care
Kaiser Permanente
Senior Care Action Network (SCAN)
U.S. Social Security Administration Disability Determination Services
U.S. Veteran's Administration
Centers for Medicare and Medicaid Services
California Department of Health Care Services
California Department of Social Services
California Department of Developmental Services
LA Homeless Services Authority
LA County Department of Children and Family Services
LA County Department of Military and Veterans Affair
LA Cash Assistance for Immigrants Program (CAPI)

Federal, State and Local Organizations
U.S. Social Security Administration Disability Determination Services
U.S. Veteran's Administration
Centers for Medicare and Medicaid Services
California Department of Health Care Services
California Department of Social Services
California Department of Developmental Services
LA Homeless Services Authority
LA County Department of Children and Family Services
LA County Department of Military and Veterans Affair
LA Cash Assistance for Immigrants Program (CAPI)

CBEST Participant Organizations (Benefits Advocacy)
Inner City Law Center
Legal Aid Foundation of Los Angeles (LAFLA)
Health Advocates
Lutheran Social Services
Los Angeles County Department of Consumer and Business Affairs
Special Services for Groups
St. Joseph's Center
Tarzana Treatment Center
The Catalyst Foundation
Volunteers of America
Watts Community Action Labor Committee (WLCAC)

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Notice to Accompany Disclosures

Sharing Records Protected by 42 CFR Part 2

Context and Instructions: Each disclosure, including all future redisclosures of Part 2 Records made with the patient's written authorization must be accompanied by this Notice to Accompany Disclosures and a copy of the consent or a clear explanation of the scope of the consent provided.

Notice: This record which has been disclosed to you is protected by Federal confidentiality rules (42 CFR part 2). These rules prohibit you from using or disclosing this record, or testimony that describes the information contained in this record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against the patient, unless authorized by the consent of the patient, except as provided at 42 CFR 2.12(c)(5) or as authorized by a court in accordance with 42 CFR 2.64 or 2.65. In addition, the Federal rules prohibit you from making any other use or disclosure of this record unless at least one of the following applies:

- Further use or disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or as otherwise permitted by 42 CFR part 2.
- You are a covered entity or business associate and have received the record for treatment, payment, or health care operations, or
- You have received the record from a covered entity or business associate as permitted by 45 CFR part 164, subparts A and E.

A general authorization for the release of medical or other information is NOT sufficient to meet the required elements of written consent to further use or redisclose the record (see 42 CFR 2.31).

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I revoke the Authorization submitted to County Programs as ______________________________
DATE

This Revocation does not affect any disclosures made prior to receiving this Revocation. This Revocation does not change the information that may be shared under State or federal laws without my consent.

____
CLIENT NAME

____
CLIENT OR RESPONSIBLE PERSON SIGNATURE DATE

If this Authorization is signed by a person other than the client, please indicate the relationship:

____
NAME RELATIONSHIP TO CLIENT

PATIENT HIM LABEL

NAME
DOB
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SEX on ID