COUNTY OF SAN LUIS OBISPO MULTI-AGENCY REFERRAL AND CLIENT RELEASE OF INFORMATION

FAX COVER SHEET

INSTRUCTIONS FOR COMPLETING THE MULTI-AGENCY REFERRAL AND CLIENT RELEASE OF INFORMATION

(This form has three parts: a fax cover sheet; an authorization to release information; and a disclosure authorization for Drug & Alcohol information)

1) Fax cover sheet (two pages). Referring agency completes. The fax cover should *not* contain Health Information. Double check the fax number.
2) Authorization Form (two pages). Referring agency completes. Participant initials the agencies they will allow on pg. 1 of 2, and signs at bottom of pg. 2 of 2.
3) Re-disclosure authorization for Drug & Alcohol information (one page). Referring agency completes.

Date: _____ # of Pages Including Cover: _____

To: _____

Program/Title: _____

Purpose for Referral: _____

Email: _____

From: _____

Title: _____

Referring Agency: _____

Phone: _____ Fax: _____

Agencies Receiving Information / Fax Number
Check the box next to the agency to receive this fax. If the agency is not shown, please write in blank at bottom.
It is your responsibility to verify the accuracy of the fax number. Faxing protected information to an incorrect number is a HIPAA breach.

☐	1. Aegis Treatment Center, LLC	(805) 461-5873	☐	The LINK - Paso Robles	(805) 462-8901
☐	2. Allan Hancock EOPS/CalWORKs	(805) 922-2606	☐	14. Family Care Network, Inc.	(805)503-6499
	3. Comm. Action Partnership of SLO (CAPSLO)	(805) 549-8388	☐	15.Family Connections Christian Adoptions	(805) 542-9285
☐	Child Care Resource Connection	(805) 541-0141	☐	16. HASLO (Housing Authority of SLO)	(805)543-4992
☐	Family Preservation/ Parent Education	(805) 541-1264		**17.Homeless Services**	
☐	Head Start/Early Head Start	(805) 549-0864	☐	40 Prado Homeless Services Center	(805) 543-4992
☐	Teen Academic Parenting Program	(805) 541-1264	☐	5-Cities Homeless Coalition (5CHC)	(805) 668-2380
☐	4. CenCal Health	(805) 681-3071	☐	ECHO	(805) 460-9162
☐	5. Center for Family Strengthening	(805)462-8901	☐	Salvation Army	No Fax
☐	6. Community Health Centers (CHC)	(805) 931-2521	☐	18.Hospital	
	7.County of SLO Health Agency			**19. Job Centers**	
☐	Drug & Alcohol Services (DAS)	(805) 781-1177	☐	DSS - North County Job Center	(805) 237-3339
☐	Mental Health (MH)	(805)781-4962	☐	DSS - South County Job Center	(805)474-2052
☐	Martha's Place	(805) 781-1405	☐	SLOCal Careers Job Center (AJCC)	(805) 439-3937
☐	Public Health	(805)781-5543	☐	SLOCal Careers Youth Program	(805)439-3937
☐	Public Guardian	(805) 781-5566	☐	20. Lumina Alliance	(805) 781-6410
	8.County of SLO Probation		☐	21.People's Self Help Housing (PSHH)	(805) 544-1901
☐	Adult	(805)781-1231		**22.School Districts**	
☐	Juvenile	(805) 781-1230	☐	Atascadero	(805)462-4421
	9.Cuesta College Programs		☐	Lucia Mar	(805) 473-1587
☐	CalWORKs	(805)546-3144	☐	Paso Robles	(805) 237-3339
☐	Foster Kinship Care Education (FKCE)	(805) 592-9402	☐	San Luis Coastal	(805) 543-6567
☐	10.Department of Rehabilitation	(805) 542-4682	☐	Templeton	(805) 434-1473
	11.Department of Social Services		☐	SLO County Office of Ed. (SLOCOE)	(805) 541-1105
☐	Adult Services	(805)788-2834	☐	23. Seneca Family of Agencies	(805) 462-8930
☐	Child Welfare Services	(805)781-1701	☐	24. Transitions-Mental Health Assoc. (T-MHA)	(805)540-6501
☐	Participant Services	(805)781-1686	☐	25. Tri-Counties Regional Center	(805) 543-8725
☐	12.Eckerd Connects	(805)439-3937	☐	26. United Way of San Luis Obispo/211	(805) 543-5317
	13.Family Resource Centers		☐	27. Veterans Services of SLO	(805) 781-5769
☐	Los Osos Cares	No Fax	☐	28. Victim Witness Assistance (DA)	(805) 781-5828
☐	San Luis Obispo/Coastal/Central	(805)543-6567	☐	29. Other:	
☐	South County SAFE	(805) 474-2025	☐	30. Other:	
☐	The LINK – Atascadero	(805)462-8901	☐	31. Other:	

This information has been disclosed to you from records that are confidential and protected by Federal Law. **Part 2 of Title 42 of the Code of Federal Regulations (42 CFR Part 2)** prohibits you from making any further disclosures of the records or information without specific written consent of the person to whom it pertains. A general authorization for the release of information is not sufficient for this purpose.

NOTE: This message, including all attachments, is intended only for the use of the person(s) to whom it is addressed, and may contain information that is confidential and subject to the attorney-client privilege. It should not be forwarded in printed or electronic form to any other person or computer. If you received this message and are not the intended recipient or an agent responsible for delivering this message to the intended recipient, you have received this message in error; please immediately notify the sender and destroy your copy. Thank you.

Please do not edit this form. For minor corrections or content revisions, contact **sjimenez@co.slo.ca.us.**

Additional Comments:

*********DO NOT PLACE ANY PROTECTED INFORMATION IN THIS AREA*********

All information must be filled out in standard blue pen.

IMPORTANT NOTE: Please ensure to follow the guidance listed below

- DO NOT PLACE ANY PROTECTED INFORMATION IN THIS AREA.
- Protected information must be sent as a separate document addressed directly to the intended recipient.
- Documentation of the conversation with the client/participant must be documented utilizing the appropriate case documentation method.
- This section is only to communicate general information. (i.e. size of clothes for the 10-year-old child, etc.)

Form 815 (English)	**COUNTY OF SAN LUIS OBISPO MULTI-AGENCY REFERRAL AND CLIENT** # RELEASE OF INFORMATION	Authorization Page 1 of 2 Rev. 06/28/2023

Date: Last Name: First Name: Middle Initial:

Address: City/State: Zip Code:

Home Number: Cellular: OK to Leave Message: Choose Language: Other Date of Birth:

Parent/Guardian: Case Type: Other Case Number:

AUTHORIZATION TO DISCLOSE AND EXCHANGE MY HEALTH CARE OR PERSONAL INFORMATION

I authorize the agencies initialed below to share my health care and personal information with each other. If I am signing as the guardian or representative for another person, I authorize the agencies that I have initialized below to share that person's health care and personal information with each other. I understand that this authorization is voluntary and that I do not have to sign it.

PLEASE INITIAL FOR EACH AGENCY AUTHORIZED TO EXCHANGE YOUR INFORMATION:

Note: The organizations listed below may only exchange information described in this document and may only exchange the information for the purposes described.

Initial Here		Initial Here	
Initial Here	Aegis Treatment Center, LLC	Initial Here	HMIS Database
Initial Here	Allan Hancock EOPS/CalWORKs		Homeless Services:
	Community Action Partnership of SLO (CAPSLO):	Initial Here	40 Prado Homeless Services Center
Initial Here	Child Care Resource Connection	Initial Here	5-Cities Homeless Coalition (5CHC)
Initial Here	Family Preservation/Parent Education	Initial Here	CAPSLO- SSVF
Initial Here	Head Start/Early Head Start	Initial Here	El Camino Homeless Organization (ECHO)
Initial Here	Teen Academic Parenting Program	Initial Here	Good Samaritan- SSVF
Initial Here	CenCal Health	Initial Here	Independent Living Resource Center
Initial Here	Center for Family Strengthening	Initial Here	People's Self Help Housing (PSHH)
Initial Here	Community Health Centers (CHC)	Initial Here	Salvation Army
	County of SLO Health Agency:	Initial Here	Hospital: Choose
Initial Here	Drug and Alcohol Services (DAS)	Initial Here	Job Centers: Choose
Initial Here	Mental Health (MH)	Initial Here	Lumina Alliance
Initial Here	Martha's Place	Initial Here	School District: Choose
Initial Here	Public Health Department	Initial Here	Seneca Family of Agencies
Initial Here	Public Guardian	Initial Here	SLO County Office of Education (SLOCOE)
Initial Here	Probation Department: Choose	Initial Here	Transitions-Mental Health Association (T-MHA)
Initial Here	Cuesta College: Choose	Initial Here	Tri-Counties Regional Center (TCRC)
Initial Here	Department of Rehabilitation	Initial Here	United Way of San Luis Obispo/211
	Dept. of Social Services (Must initial next to each department)	Initial Here	Veterans Services Department – County of SLO
Initial Here	Adult Services	Initial Here	Victim/Witness Program – County SLO D.A.
Initial Here	Child Welfare Services	Initial Here	Other:
Initial Here	Participant Services	Initial Here	Other:
Initial Here	Eckerd Connects	Initial Here	Other:
Initial Here	Family Resource Centers: Choose	Initial Here	Other:
Initial Here	Foster Family Agency: Choose	Initial Here	Other:
Initial Here	Family Care Network, Inc. (FCNI)	Initial Here	Other:
Initial Here	Housing Authority of San Luis Obispo (HASLO)	Initial Here	Other:

COUNTY OF SAN LUIS OBISPO MULTI-AGENCY REFERRAL AND CLIENT RELEASE OF INFORMATION

HEALTHCARE OR PERSONAL INFORMATION THAT CAN BE SHARED BY THE IDENTIFIED AGENCIES

NOTE: THIS AUTHORIZATION FORM ALLOWS DISCLOSURE OF ALL OF YOUR HEALTH AND SOCIAL SERVICES RECORDS UNLESS YOU SPECIFY A SPECIFIC LIMITATION.

The identified agencies can share any and all information from your health care records or personal records or from the healthcare records or personal records of the person for whom you are authorizing this disclosure, for the purposes listed below. The information may come from your San Luis Obispo County physical health records, mental health records, or drug and alcohol treatment records. The information may also come from your Social Services records or the records of any other agency you authorized to share your information. The information used, disclosed or shared may be written or oral, and will only include information necessary to achieve the intended purpose or referral.

Initial Here **Initial here to indicate you understand we will share your behavioral health information.**

Initial Here **Initial here to indicate you understand we will share your Drug and Alcohol Program Information.**

Describe the type and amount of Drug and Alcohol Program Information that can be disclosed:

Initial Here	Drug and Alcohol Test Results	Initial Here	Substance Use Diagnosis
Initial Here	Drug and Alcohol Treatment Plan	Initial Here	Drug and Alcohol Program Attendance
Initial Here	Drug and Alcohol Payment Information	Initial Here	Discussions with my Drug and Alcohol Counselor

PURPOSE AND LIMITATIONS ON THE USE OF YOUR HEALTHCARE OR PERSONAL INFORMATION

The information will be used by the identifed agencies to refer you to and request services from agencies that you authorized in this document. The information may also be used to coordinate care or to coordinate services between the agencies. These services may be in areas such as health care, housing, employment, education, nutrition, parenting, child welfare, and/or other traditional social services.

This authorization to release the above information will **expire two years from the date signed** or will expire on: _____ (**Not more than 2 years.**)

I understand that:

- I understand that I have a right to receive a copy of this authorization.
- I have the right to revoke this authorization verbally, or by sending a signed notice to:
  - County Privacy Officer: 2180 Johnson Ave., San Luis Obispo, CA, 93401
  - Or via e-mail at privacy@co.slo.ca.us ; or call (855) 326-9623
  - This authorization will cease on the date my valid revocation request is received. I also understand that any information released prior to a revocation of this authorization shall not be a breach of my confidentiality.
- 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/Departments/Health-Agency.aspx
- My treatment, enrollment, or eligibility for benefits will not be affected if I do not sign this authorization.
- Upon request, I may inspect or obtain a copy of the health information that I allow to be disclosed.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA); for example, if I allow disclosure to a family member.
- 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.
- I understand that alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C.F.R. Pts. 160 and 164, and cannot be re-disclosed without my written consent unless otherwise provided for in the regulations.

Client Signature*:	**Print Name:**	**Date:**
Representative Signature:	**Relation:**	**Date:**
Employee Name:	**Organization:**	
Employee Signature:	**Employee Title:**	**Date:**

NOTE: A verbal signature may be accepted BUT a wet signature is required within 30 days from date of verbal signature.

Form 815 (English)	COUNTY OF SAN LUIS OBISPO MULTI-AGENCY REFERRAL AND CLIENT RELEASE OF INFORMATION	Re-disclosure Addendum Page 1 of 1 Rev. 06/28/2023

ADDITIONAL CONSENT FOR RECIPIENTS OF PROTECTED DRUG AND ALCOHOL TREATMENT INFORMATION TO SHARE THE INFORMATION WITH OTHERS

NOTE: This page is to be filled out if Drug and Alcohol Treatment information that was shared by the client's Drug and Alcohol Treatment provider is intended to be further disclosed (re-disclosed) by the initial recipients to another individual agency (such as the Superior Court, District Attorney, Probation, Department of Social Services). **If completed, this page must be attached to page 1 and 2 of this Authorization form.**

Full Client Name:		**Date of Birth:**	

I authorize the disclosure of my Drug and Alcohol Treatment information or the information for the person for whom I am signing, to be shared by the following agencies:

Initial Here	Name of Agency:	
Initial Here	Name of Agency:	
Initial Here	Name of Agency:	
Initial Here	Name of Agency:	
Initial Here	Name of Agency:	
Initial Here	Name of Agency:	
Initial Here	Name of Agency:	
Initial Here	Name of Agency:	
Initial Here	Name of Agency:	

DRUG AND ALCOHOL TREATMENT INFORMATION THAT CAN BE SHARED BY THE IDENTIFIED AGENCIES

Initial Here	Any information related to your participation in the Drug and Alcohol Program including your status as a patient, date of admission, initial evaluation, assessment results/ history, attendance, date of discharge, discharge plan and discharge status.
Initial Here	Summary of your treatment plan, progress in the program, and compliance.
Initial Here	Any drug test results including urinalysis, breathalyzer/ patching test results.
Initial Here	Any personal information about your household, relationships and children including observations and evaluations of minors with whom you interact.

PURPOSES AND LIMITATIONS ON THE USE OF YOUR DRUG AND ALCOHOL SERVICES INFORMATION

The information described above may be used, disclosed and/or re-disclosed by and between the agencies listed above to assist them in handling your Department of Social Services case, your Family Court case, your Probation case, your court/criminal Justice case and/or any other matter related to this authorization.

I voluntarily sign this authorization to disclose my Drug and Alcohol Program information to the agencies listed above. I understand these agencies will share this information with each other.

Client Signature*:	**Print Name:**	**Date:**
Representative Signature:	**Relation:**	**Date:**
Employee Name:	**Organization:**	
Employee Signature:	**Employee Title:**	**Date:**

NOTE: A verbal signature may be accepted BUT a wet signature is required within 30 days from date of verbal signature.