**Coordinated Care Authorization**

*Authorization for the Disclosure of Health and Other Personal Information*

By signing this form below, you will allow certain organizations and individuals to use and share your health and other personal information for purposes related to your treatment and care. They will be able to share your information through an electronic health record system maintained by the California Mental Health Services Authority called SmartCare.

**1. Who will share my information if I sign?** By signing, your information may be shared by and with any of the following that provide services to you (your providers) and which are connected to SmartCare:

* + Health care providers, such as doctors, hospitals, and pharmacies.
  + Mental health providers and substance use disorder providers.
  + School-based providers, such as nurses, social workers, and counselors.
  + San Diego County health care agencies.
  + The San Diego County Office of the Public Conservator, only when performing their core care functions of reviewing referrals and arranging placement and treatment.
  + Housing providers that help people find a home.
  + Any jail staff who provide behavioral health services to you while you're incarcerated.
  + Advocacy agencies, such as the Consumer Center for Health Education and Advocacy (CCHEA) or Jewish Family Services (JFS), only when you request they look into your care.

Your providers also include any health insurers that provide you with coverage, including any of your mental health plans.

**2. Will my providers be able to use and share my information for any reason?**

No, your providers can only use and share your information for limited purposes. Your providers may use and share your information to provide you with medical or behavioral health care, to coordinate your care, to determine how much should be paid for services provided to you, or to improve the quality of care.

**3. What types of information about me may be shared if I sign?** Your providers may share the following types of information about you:

* Medical information, such as information about illnesses, injuries, medical treatments, allergies, medications.
* Behavioral health information, such as any mental health conditions or alcohol or drug use disorders you may have, which could include information on your substance use history and medications, diagnoses, and drug test results.
* School services information, such as an Individualized Education Program, and any records of medical or behavioral health services provided in schools.

**4. Can I obtain a list of providers who saw my information?**

Yes, we can provide you with a list of those who looked at information about you. Just ask us.

**5. Can my providers who see information about me in SmartCare disclose it to others?**

Yes, but if permitted by state and federal laws. In some cases your information may no longer be subject to federal privacy laws once it is shared. Certain substance use disorder information about you may be redisclosed if permitted under the Health Insurance Portability and Accountability Act, except that you do not authorize the disclosure of such information for uses in civil, criminal, administrative, or legislative proceedings against you.

**6. When does my authorization expire?**

You authorize your providers to access your information for 1 year after the date you sign, unless you indicate below that you want authorization to last a different period of time.

**7. Can I change my mind and revoke my consent later?**

Yes, you have a right to revoke this form at any time. If you want to revoke, you should contact us at your treatment provider. If you revoke, some of your providers will still be legally permitted to see some information about you via SmartCare in certain circumstances, but other information (such as your substance use disorder information) typically will be inaccessible to them.

**8. If I am a parent or guardian, can I sign on behalf of my child?**

Yes, you may do so by including your name as the Legal representative of your child and by signing below. Your child should also sign if your child is 12 or older since your child has the right to authorize disclosure of certain types of information. If you sign on behalf of a child, the form will expire when your child turns 18.

**9. Do I have to sign this?**

No, signing this form is voluntary, and declining to sign this form will not impact your ability to get medical care, mental health or substance use treatment, health insurance, or any government benefits. If you don’t sign, some of your providers still may still see some of your information in SmartCare in accordance with the law, but the information accessible to them will be more limited than if you provided authorization.

**10. Can I have a copy of this form?**

Yes, you have a right to obtain a copy of this form. Just ask us for one.

By signing below, I consent to the disclosure of my information as described in this form. Further, by including my phone number below, I consent to the receipt of texts or calls to communicate with me about my consent and how my information may be shared (standard message and data rates may apply).

**CLIENT INFORMATION**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If signed by someone other than the client:*

Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent:**

I give consent for sharing of information across all services within \_\_\_\_\_\_\_\_\_\_\_\_\_County of San Diego's instance of SmartCare.

Yes  No Start Date: Expiration Date:

**Restrictions:**

I want the following staff to NOT have access to my record:

Details on any other restrictions of sharing my data. This will prompt a review by the Privacy Officer. This does not guarantee the restriction of this data as specified in the text.

**Signatures**

Client Signature: Date:

Printed Name:

Guardian Signature: Date:

Printed Name:

Staff Signature: Date:

Printed Name: