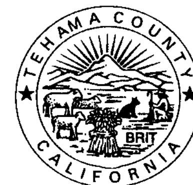
TEHAMA COUNTY SYSTEM OF CARE

Authorization for Release of Medical Information to Multidisciplinary Team



Client Name:______________________________ **Birth date**: _______________

I hereby authorize: ***(PLEASE INITIAL ALL THAT APPLY)***

TEHAMA COUNTY HEALTH SERVICES AGENCY

_____ Clinic Division

_____ Drug & Alcohol Division

_____ Mental Health Division

_____ Public Health Division

OTHER HEALTH CARE

_____ St. Elizabeth Community Hospital
Specify program/dept ________________

_____ Health Care Provider (name):
____

_____ Mental Health Care Provider
(Name): _________________________

_____ Other ___________________________

to release client's medical information to the members of the following *Tehama County Multidisciplinary Team:* ☐ Children's System of Care ☐ Adult System of Care ☐ Older/Dependant Adult MDT **I understand the *Team* is made up of the following individuals and organizations:** ***(PLEASE INITIAL ALL THAT APPLY)***

TEHAMA COUNTY HEALTH SERVICES AGENCY

_____ Clinic Division

_____ Drug & Alcohol Division

_____ Mental Health Division

_____ Public Health Division

OTHER HEALTH CARE

_____ St. Elizabeth Community Hospital
Specify program/dept ________________

_____ Health Care Provider (name):
____

_____ Mental Health Care Provider
(Name): _________________________

_____ Other ___________________________

See next page for additional Team members.

CRIMINAL JUSTICE

_____ Tehama County Probation Dept.

_____ Tehama County Sheriff's Dept.

_____ Red Bluff Police Dept.

_____ Corning Police Dept.

_____ California Dept. Of Corrections, Parole Division

EDUCATION

_____ Tehama County Dept. of Education

School: ___________________________

School: ___________________________

School: ___________________________

_____ Healthy Start

_____ Head Start

_____ Even Start

SOCIAL SERVICES

_____ Tehama County Department of Social Services – Specify program: ____________________________

_____ In Home Support Services (IHSS)

_____ North Valley Catholic Social Services

_____ Children First

_____ New Directions to Hope

_____ California Dept. Of Rehabilitation

_____ Far Northern Regional Center

_____ Child Care Provider (name): ______________________________

_____ Alternatives to Violence

_____ Family Service Agency

_____ Employment Development Dept.

_____ Residential Care Provider (name): ____________________________

_____ Job Training Center

_____ Other: _______________________

OTHER

_____ Other: _______________________

_____ Other: _______________________

This authorization is voluntary. The name counseling/Health Care Treatment provider(s) may not condition eligibility for benefits, enrollment, or treatment upon signing this release.

Client Name:________________________ **Tehama County System of Care**

Client medical information refers to written records, whenever created, and to *direct written* and *oral communications* with the members of the **Team**. Client medical information includes only records and communications within the following category(s): ***(PLEASE INITIAL ALL THAT APPLY)***

1. _____ Summary of medical, psychiatric, developmental, drug and alcohol, and psychosocial histories.
2. _____ Periodic reports to evaluate patient progress in treatment
3. _____ HIV Test Results
4. _____ Other:____
5. _____ Other:____

The purpose of this authorization is to allow the **Team** to gather the medical information necessary to develop a plan of comprehensive services and make appropriate referrals. The information released, documents reviewed, and matters discussed are confidential and cannot be used in criminal proceedings.

Note: Client medical information disclosed because of this release may be re-disclosed and no longer protected by *federal* confidentiality regulations. However, *California* state law prohibits recipients of client medical information from re-disclosing this information except with your written authorization or as specifically required or permitted by law. Client medical information released by Tehama County Drug & Alcohol Services are further protected by 42 C.F.R. part 2.

I understand that I may revoke this authorization at any time, except to the extent that it has been relied upon by the named Counseling/Health Care Treatment provider(s). The revocation may be made anytime by telephone, orally in person, or in writing to Tehama County Health Services Agency, PO Box 400, Red Bluff, California, 96080. If this authorization is not revoked, it will expire one year from the date it is signed.

I acknowledge that I have received a copy of this authorization.

______________________________ ______________

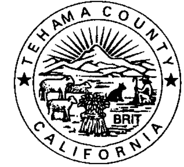
Client Signature Date

______________________________ ______________________________

Printed Name **Parent, Guardian, Conservator or Personal Representative**

A photocopy of this authorization is as effective as the original.

TEHAMA COUNTY SYSTEM OF CARE



Authorization for Release of ***<u>Non-Medical</u>*** *Information*
to the Multidisciplinary Team

The purpose of this authorization is to allow the **Team** to gather the non-medical information necessary to develop a plan of comprehensive services and make appropriate referrals for children, teenagers, and/or adults and their families who are participating in the following *Tehama County Multidisciplinary Team (MDT):* ☐ Children's System of Care ☐ Adult System of Care ☐ Older/Dependant MDT

Please initial all that apply. I hereby give my permission for each of the agencies initialed below to release to all of the other agencies initialed below confidential non-medical information regarding:

Client Name: ________________________________ Birth Date: _______________________

Tehama County Health Services Agency	**Other Health Care**	**Criminal Justice**
_____ Drug & Alcohol Division	_____ St. Elizabeth Community Hospital	_____ Tehama County Probation Dept.
_____ Mental Health Division	_____ Greenville Rancheria	_____ Tehama County Sheriff's Dept.
_____ Clinic Division	_____ Health Care Provider (name):_______________________	_____ Red Bluff Police Dept.
_____ Public Health Division	_____ Health Care Provider (name):_______________________	_____ Corning Police Dept.
		_____ California Dept. Of Corrections, Parole Division
Education	**Social Services**	
_____ Tehama County Dept. Of Education	_____ Tehama County Department of Social Services	_____ Family Service Agency
School: ____________________________	_____ Right Road Recovery Programs	_____ Employment Development Dept.
School: ____________________________	_____ North Valley Catholic Social Services	_____ Learning Center of Tehama County
School: ____________________________	_____ Job Training Center	_____ Far Northern Regional Center
_____ Healthy Start	_____ Alternatives to Violence	_____ Other:__________________
_____ Head Start	_____ Dept. Of Rehabilitation	_____ Child Care Provider (name):
_____ Even Start	_____ Residential Care Provider (name): _____________________	_____New Directions to Hope

<u>Other</u>

_____ Other:__________________	_____ Other:__________________	_____ Other:__________________

Client Name:________________________ **Tehama County System of Care**

Confidential non-medical information that may be disclosed pursuant to this authorization includes the following types of information initialed below, but does **not** include medical records or protected health information.

_____ Information contained in the school confidential file	_____ Information contained in the school cumulative file
_____ Law Enforcement Contacts	_____ Status of Medi-Cal eligibility
_____ Pertinent disposition of legal status	_____ Other ______________________________
_____ Other ______________________________	_____ Other ______________________________

I understand that my records are protected under State and Federal Confidentiality regulations and cannot be re-disclosed without my written consent unless otherwise provided for in those regulations. 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 ONE YEAR AFTER THIS DATE.**

Service discussed within the scope of this authorization is confidential, with these exceptions: (1) mandated reporters are compelled by law to inform an appropriate other persons(s) if they hear and believe that you or a family member are in danger of hurting yourself or someone else; (2) if there is reasonable suspicion that a child, dependent adult, and/or elderly adult has been abused; and (3) under the Tarasoff principles if you have made a threat to harm an identified victim, both the victim and law enforcement will be notified of this threat.

I understand that I have a right to receive a copy of this authorization.

________________________________ ________________

Signature Date

________________________________ ________________________________

Printed Name **Parent, Guardian, Conservator or Personal Representative**

A photocopy of this authorization is as effective as the original.