COUNTY OF LOS ANGELES
Public Health

Instructions for Completing the SAPC Consent for Treatment and Care Coordination Form

This purpose of this consent form is to give written permission for the release and exchange of your health information, including information protected under **42 CFR Part 2** (substance use disorder information) between your current, past, and future treating providers within the SAPC Provider Network, and to the outside entity(ies) or individual(s) specified in this consent form at the request or you or your authorized representative for the purpose of the client's treatment and care coordination. For SUD information, the purpose of consent and disclosure must be consistent with **42 CFR Part 2** requirements and all applicable Federal and State laws. Your authorization is voluntary and you may refuse to sign. Please take a moment to read the instructions below.

Read Each Section Carefully

This form includes several sections describing:

- **What information** may be shared
- **Who** may send and receive the information
- **Why** the information is being shared
- **How long** the authorization lasts
- **Your rights** to revoke or limit the authorization to release information

Please **read and review each section** thoroughly before signing.

Specify What Information May Be Released

You may choose to limit the type or amount of information released. You may authorize the release of:

- Your entire health record, **or**
- Specify the information you authorize for use and disclosure

Who May Share and Receive Your Information

You must specify who you are authorizing the sharing of information. This can include:

- SAPC's Provider Network or Agency(ies), **or**
- Select treating providers in SAPC's Provider Network or Agency(ies), **or**
- One or more entity(ies)/individual(s) or intermediary(ies) outside of SAPC's Provider Network or Agency(ies)

Please refer to Section II "Entities Authorized to Share Health Information".

Review Your Rights Under HIPAA and 42 CFR Part 2

This form states your rights under Federal and State laws. You have the right to:

- **Refuse to sign** this authorization
- **Revoke** your authorization at any time in writing or in-person
- **Receive a copy** of the completed form
- **Limit** what information is shared
- **Expect confidentiality protections**, including redisclosure limits

Please refer to Section IV "Other Important Information" and Section VI "Notice to Accompany Disclosures" for more information related to your rights under HIPAA and 42 CFR Part 2.

Expiration of Authorization

This authorization will remain in effect for as long as you receive services from the SAPC Provider Network unless you choose to revoke it.

Please refer to Section IV "Other Important Information" and Section VII "Revocation of Consent" for more information on your authorization rights.

Revoking Your Authorization

You may revoke your authorization at any time by notifying your treating provider or program in writing or in-person. Revocation does **not** undo information already shared before the revocation was received.

Please refer to Section IV "Other Important Information" and Section VII "Revocation of Consent" for more information on how to revoke your authorization.

Electronic Exchange and Security

All disclosures—including those made electronically—must comply with:

- **HIPAA** requirements
- **42 CFR Part 2**
- Other applicable Federal and State **confidentiality laws**

Sign and Date the Form

Your signature confirms that:

- You **understand** the information on the form
- You **authorize the release of the information** described
- You **understand your rights** under HIPAA and 42 CFR Part 2

If you are signing as a **legal representative**, you must indicate your authority to do so. Examples of legal authority include Parent, Legal Guardian, Conservator, Executor of Estate, Power of Attorney, and/or Next of Kin. You will be required to provide additional documentation to corroborate your authority or relationship.

If you are signing as a witness for signature by mark, please fill out the appropriate section with your information.

Return the Completed Form

Return the signed form to the provider, program, or agency responsible for processing your request. You may request a copy for your records.

COUNTY OF LOS ANGELES
Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL

CONSENT FOR RELEASE OF SUBSTANCE USE DISORDER HEALTH INFORMATION FOR TREATMENT AND CARE COORDINATION

Purpose of Consent and Disclosure: This consent form authorizes the release of 42 CFR Part 2 protected substance use disorder (SUD) health information between the client's current, past, and future treating providers within the SAPC Provider Network, and to the outside entity(ies) or individual(s) specified in this consent form at the request of the client or their authorized representative for the purpose of the client's treatment and care coordination. Please indicate whether you are authorizing the sharing of information between your current, past, and future treating providers within SAPC's Provider Network, or between SAPC's Provider Network and one or more outside entity(ies)/individual(s) or intermediary(ies) outside of SAPC's Provider Network by selecting one or both of the options below:

☐ Within SAPC's Provider Network ☐ Outside SAPC's Provider Network

The selection made in this section must match the selection made in Section II. Entities Authorized to Share Health Information.

I. CLIENT INFORMATION

Name (Last, First, and Middle):	Date of Birth:	Medi-Cal #:
Email Address: By providing your email address, you are authorizing SAPC and SAPC's Provider Network to contact you by email.	Phone Number:	Last 4 Digits of SSN:
Address:		Sage ID #:

II. ENTITIES AUTHORIZED TO SHARE HEALTH INFORMATION

I authorize my current, past, and future treating provider(s) to exchange my 42 CFR Part 2 protected SUD health information with the entity(ies) specified below pursuant to this request for the purpose of my treatment and care coordination.

Select one or more of the options below. Only one of the 'In SAPC Provider Network' options may be selected. The option(s) selected below must match the option(s) selected at the top of this document.

☐ **SAPC's Entire Provider Network:** With all treating providers in SAPC's Provider Network. If this is the only selection, skip to Section III. Scope of Disclosures.

☐ Select **SAPC Provider Agency(ies):** With the select treating provider(s) in SAPC's Provider Network specified below.

☐ **Outside SAPC's Provider Network:** With the entity(ies)/individual(s) or intermediary(ies) outside of SAPC's Provider Network specified below.

Use the spaces provided below to enter the contact information of the select provider(s) in SAPC's Provider Network and/or outside entity(ies) you are authorizing the release of your protected SUD information to. If additional space is needed, please attach a page with the listed entities to the end of this consent form.

1. Entity Name: _____

   Address: _____

   Phone #: _____ Fax #: _____

   Email: _____ Website: _____

2. Entity Name: _____

Address: _____

Phone #: _____ Fax #: _____

Email: _____ Website: _____

3. Entity Name: _____

Address: _____

Phone #: _____ Fax #: _____

Email: _____ Website: _____

III. SCOPE OF DISCLOSURE

I authorize the entities indicated in Section II to share the protected health information specified below.

Select one of the options below.

☐ My entire health record

☐ Other: _____

Specify the information you authorize for use and disclosure.

IV. OTHER IMPORTANT INFORMATION

By signing this Consent form, I understand that:

- **Expiration of Consent -** This Authorization will remain in effect for as long as I receive services from SAPC's Provider Network or unless otherwise revoked.
- My alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise permitted by the regulations.
- I have a right to receive a copy of this Consent form. A copy of this Consent form is as valid as the original.
- **Redisclosure Information** - Information related to alcohol or drug treatment disclosed to a covered entity or business associate may be redisclosed in accordance with the permissions contained in the HIPAA regulations.
- **Limitations for Redisclosure** - Disclosed information cannot be redisclosed for civil, criminal, administrative, and legislative proceedings against the client without an additional Consent form that is solely for this purpose consistent with the 42 C.F.R. Part 2. Disclosures for legal purposes require a separate consent.
- I understand that information used or disclosed pursuant to the consent form may be subject to redisclosure by the recipient and no longer protected by 42 C.F.R. Part 2.
- I have the right to revoke this Consent at any time in writing or in person with my treating substance use provider, except to the extent that my provider or other lawful holder has already acted in reliance on it. I may use the Revocation Consent section on this Consent form to terminate this Consent form in writing. Once my Revocation of Consent is received, my provider or SAPC will revoke the Consent for future release of information. I understand disclosures made prior to revoking this consent form cannot be retrieved and the entities to whom the disclosures were made to are not required to return or dispose of the disclosures.

V. SIGNATURE OF CLIENT OR LEGAL REPRESENTATIVE

By signing below, I acknowledge I have read the Consent form and understand my signature authorizes the disclosure of my health information as described on this form. I understand that signing this form is voluntary and I have the right to refuse to sign.

Name and Signature of Client or Client's Legal Representative:

If the client cannot write, they may make a mark on the signature line. Signature by mark requires two witnesses. A witness must write the client's name on the line designated for the client's name and write their own name and sign on one of the designated witness spaces below. A second witness must write their name and sign on the other witness space to acknowledge the client's signature by mark.

_____ _____ _____ / _____ / _____
Print Name (First Middle and Last) Signature Month Day Year

If signed by Client's Legal Representative, state relationship and authority to do so:

_____

If the client cannot write and has provided a mark as their signature above, two witnesses are required to complete the witness section by writing their names and signing below.

1. _____
Print Witness Name (First Middle and Last)

_____
Signature

2. _____
Print Witness Name (First Middle and Last)

_____
Signature

VI. NOTICE TO ACCOMPANY DISCLOSURES

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:

(i) 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.

(ii) You are a covered entity or business associate and have received the record for treatment, payment, or health care operations, or

(iii) 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).

VII. REVOCATION OF CONSENT

I have the right to revoke this Consent form at any time by completing this section and providing my Revocation of Consent by mail or in person to my treating provider, except to the extent that my provider or other lawful holder has already acted in reliance on it.

Treating Substance Use Provider Agency's Address:

Organization Name: _____

Street Address (Line 1): _____

Street Address (Line 2: Apt/Suite/Unit): _____

City, State, and Postal Code: _____

Once my Revocation of Consent is received, my provider will revoke the Consent form for future release of information. Disclosures made prior to receiving the revocation cannot be retrieved.

By signing below, I revoke my Consent for future release of information. I understand that any disclosures made prior to the receipt of this revocation cannot be undone or retrieved.

Name and Signature of Client or Client's Legal Representative:

If the client cannot write, they may make a mark on the signature line. Signature by mark requires two witnesses. A witness must write the client's name on the line designated for the client's name and write their own name and sign on one of the designated witness spaces below. A second witness must write their name and sign on the other witness space to acknowledge the client's signature by mark.

_____ _____ _____ / _____ / _____

Print Name (First Middle and Last) | Signature | Month | Day | Year

If signed by Client's Legal Representative, state relationship and authority to do so:

_____

If the client cannot write and has provided a mark as their signature above, two witnesses are required to complete the witness section by writing their names and signing below.

1. _____ 2. _____

Print Witness Name (First Middle and Last) | Print Witness Name (First Middle and Last)

_____ _____

Signature | Signature

Clients who submitted a Release of Information Consent form directly to SAPC may return the completed Revocation of Consent form through secure email or by mail to the address listed below. A copy of their official government-issued identification must be included to verify the legitimacy of the request.

SAPC's Mailing Address
Substance Abuse Prevention and Control
1000 South Fremont Ave.
Bldg. A-9 East 3rd Floor Box 34
Alhambra, CA 91803

Email Address:
SAPC-HIM@ph.lacounty.gov

Please note: Revocation requests submitted to SAPC from clients who did not complete Release of Information Consent form directly with SAPC, or requests submitted without a copy of a valid government-issued ID, will not be processed.

How to fill out the SAPC Consent for Treatment and Care Coordination Form

Purpose of Consent and Disclosure (Top of Form)

This section determines **to whom your SUD information may be shared**. Make sure your choices here **match Section II**.

Step 1 — Read the purpose statement.

1. This explains that the form authorizes release of 42 CFR Part 2 protected SUD information "**for the purpose of the client's treatment and care coordination**."

Step 2 — Choose one or more options

1. Choose one or both checkboxes:
    a. **Within SAPC's Provider Network** Select if you want your information shared only among SAPC-contracted SUD providers.
    b. **Outside SAPC's Provider Network** Select if you want your information shared with outside entities (e.g., primary care, mental health, probation, specific hospital, yourself, etc.).

Section I — Client Information

Fill in your personal information so SAPC and your providers can correctly identify your record.

1. **Name:** Write your full legal name (Last, First, Middle).
2. **Date of Birth:** Use MM/DD/YYYY.
3. **Medi-Cal #:** Enter your Medi-Cal number, if you have one.
4. **Email Address:** Enter an email you check regularly.
5. **Phone Number:** Best telephone number to reach you.
6. **Last 4 Digits of SSN:** Enter only the last four digits of your Social Security Number. If you do not have an SSN or know what your SSN is, then please leave blank.
7. **Address:** Your current mailing address.
8. **Sage ID #:** Provide your Sage EHR medical record number, if known. If unknown, leave blank or ask your provider.

Section II — Entities Authorized to Share Health Information

This section identifies **who may exchange your SUD information** based on your selection(s).

Step 1 — Choose one or more options

Select the option(s) that match your needs:

1. **SAPC's Entire Provider Network**
    a. Select if you would like your provider to be able to exchange data with the whole SAPC SUD provider network in order to fully coordinate your care across agencies.
    b. If this is the only box checked, you may skip to Section III.
2. **Select SAPC Provider Agency(ies)**
    a. Select if you want to authorize your SUD provider to exchange information only with specific other SAPC providers.
    b. You will need to provide the specific requested information for each SAPC provider that you would like your health information to be requested from or shared with.
3. **Outside SAPC's Provider Network**
    a. Select if you want your information shared with outside entities (e.g., Department of Mental Health, Department of Health Services, your Primary Care Physician, hospital, school, etc.).
    b. You will need to provide the specific requested information for each entity that you would like your health information to be requested from or shared with.

Step 2 — Fill in entity details (if applicable)

For each SAPC provider or outside entity you authorize, please fill in:

- **Entity Name** (full name, avoid abbreviations)
- **Address** (full mailing address)
- **Phone Number** (with area code)
- **Fax #** (if known)
- **Email** (if known)
- **Website** (optional)

Step 3 — Add additional pages if needed

If you have more than three entities, attach a separate sheet listing the rest.

Section III — Scope of Disclosure

This section defines **what information** may be used or disclosed.

Step 1 — Choose one option

- ☐ **My entire health record** Select this if you want your full SUD record available for Care Coordination.
- ☐ **Other:** Select this if you want to limit what is shared.

Step 2 — If selecting "Other," specify exactly what may be disclosed

Be as specific as possible so providers know what is allowed.

Examples:

- "Treatment dates only"
- "Assessment and diagnosis only"
- "Medication list"
- "Proof of program participation"
- "Progress reports only"

Section IV — Other Important Information

You do not need to write anything in this section. Read each subsection carefully.

- **Expiration:** Your Consent stays active until you revoke it.
- **Protections:** Your records are protected by federal laws under **42 CFR Part 2** and **HIPAA**.
- **Right Not to Sign:** You can refuse to sign, but then **your record will not be released**.
- **Right to a Copy:** You may request a copy of the signed consent.
- **Redisclosure:** Per HIPAA, some of your information may be redisclosed by the receiving agency under limited circumstances.
- **Legal Protections:** Your information cannot be used in legal proceedings without a separate consent.
- **Right to Revoke:** You may revoke this consent at any time. Information already shared cannot be taken back.

Section V — Signature of Client or Legal Representative

This is where you formally authorize the release.

1. **Print Name:** Your full legal name.
2. **Signature:** Sign your name.
    a. If you cannot write, you may sign with a mark.
    b. If signing by mark, **two witnesses** must complete the witness section.
3. **Date:** Enter the date of signing.

4. **If signed by a Legal Representative:**
    a. State the relationship (e.g., parent, guardian, etc.).
    b. State the authority (e.g., court order, conservatorship, etc.).

5. **Witness Section *(only if client signs by mark)***
   Two witnesses must:
   - Print their names legibly
   - Sign their names

If a **legal representative** signs, they must state their relationship and legal authority to do so. If the client **signs with a mark**, two witnesses must print and sign their names.

Section VI — Notice to Accompany Disclosures

This is the required 42 CFR Part 2 confidentiality notice that will accompany your information. No writing is required in this section. The Notice to Accompany Disclosures is a confidentiality notice that will accompany records released as authorized by the signing of this form. The confidentiality notice notifies the receiver that the records being received are protected under State and Federal confidentiality laws and cannot be shared with other entities not authorized by this consent form.

Section VII — Revocation of Consent

Complete this section **only when you want to revoke your consent (i.e. in the future)**.

Step 1 — Provider Information

Fill in the treating provider's:

- **Organization Name**
- **Full mailing address**

Step 2 — Revocation Signature

1. **Print your name**
2. **Sign your name (or make a mark**).
3. **Date the revocation (MM/DD/YYYY**)
4. If a **legal representative** signs, **state relationship and authority** to do so
5. If submitting directly to SAPC, please **include a copy of your government-issued ID** in order to verify your identity

Step 3 — Witnesses (if signing by mark)

Two witnesses must print and sign their names.

Step 4 — Submit the revocation

If you originally submitted the consent directly to SAPC, you may send the revocation:

- **By secure email** to SAPC-HIM@ph.lacounty.gov (must include a copy of your government-issued ID)
- **By mail** to the SAPC address listed on the form

Please send revocations to your provider, agency, or to SAPC using the instructions on the form.

Additional Definitions

Authorization / Consent

A written, signed document that meets all 42 CFR Part 2 requirements, including:

- Purpose of disclosure
- Who may disclose
- Who may receive
- What information may be shared
- Expiration
- Signature and date

Each SAPC ROI form is designed to meet these requirements for its specific purpose

Care Coordination

Communication and collaboration between providers to support a client's treatment, referrals, case management, and continuity of care.

Client

The individual receiving substance use disorder (SUD) services. The client is the person whose protected health information (PHI) may be shared when they sign an ROI.

Entity

Any organization, agency, provider, court, attorney, or individual authorized to receive or disclose SUD information. Examples: SAPC providers, DHCS, Managed Care Plans, courts, probation, primary care providers.

Legal Proceedings

Any criminal, civil, administrative, or legislative process where SUD information may be requested or used against the client. Examples: court hearings, probation, child welfare cases, social security benefit determination hearings.

Legal Representative

A person legally authorized to make decisions on behalf of the client. Examples:

- Court-appointed conservator
- Legal guardian
- Parent of a minor They may sign the ROI only when they have documented legal authority.

Minimum Necessary Standard

Under HIPAA definitions, the least amount of information needed to fulfill the purpose of the consent may be shared.

Payment & Healthcare Operations

Administrative activities needed to bill, pay, or manage SUD services, including:

- Medi-Cal billing
- Eligibility checks
- Utilization review
- Quality improvement
- Audits and compliance reviews

Redisclosure

Any sharing of SUD information after the initial disclosure. Under 42 CFR Part 2, redisclosure is **permitted**, except for legal proceedings.

Revocation of Consent

The client has a right to withdraw their consent at any time. Withdrawing consent cannot undo past disclosures already made when the consent was in place. Revocation must be in writing or completed using the revocation section of the ROI form.

Third-Party Payor

Any entity responsible for paying or reimbursing SUD services other than the client themselves. Examples: Medi-Cal, DHCS, Managed Care Plans, private insurance.

Treating Provider / SAPC Provider Network

Any SUD treatment program contracted with LA County SAPC, including outpatient, residential, OTP, withdrawal management, and recovery support programs.

Witness

A person who observes the client sign the ROI **by mark** (when the client cannot write a signature). Two (2) witnesses must print and sign their names in order for mark to be considered valid.