



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 re-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. Agencies **can't** re-disclose Drug & Alcohol

Date: _____ # of Pages Including Cover: _____ From: _____

To: _____ Title: _____

Program/Title: _____ Referring Agency: _____

Purpose for Referral: _____ Phone: _____ Fax: _____

Email: _____

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.

<input type="checkbox"/>	1. Allan Hancock EOPS/CalWORKs	(805) 922-2606	<input type="checkbox"/>	Good Samaritan Shelter (SSVF)	(805) 357-5902
<input type="checkbox"/>	2. Comm. Action Partnership of SLO (CAPSLO)	(805) 549-8388	<input type="checkbox"/>	40 Prado Homeless Services Center	(805) 541-5870
<input type="checkbox"/>	Child Care Resource Connection	(805) 541-0141	<input type="checkbox"/>	13. Hospital	
<input type="checkbox"/>	Family Preservation/ Parent Education	(805) 541-1264	<input type="checkbox"/>	14. Independent Living Program (ILP)	(805) 503-6499
<input type="checkbox"/>	Head Start/ Early Head Start	(805) 549-0864	<input type="checkbox"/>	15. Job Centers	
<input type="checkbox"/>	Teen Academic Parenting Prog (TAPP)	(805) 541-1264	<input type="checkbox"/>	America's Job Centers of CA - SLO	(805) 903-1411
<input type="checkbox"/>	3. CenCal Health	(805) 681-3071	<input type="checkbox"/>	DSS - South County Job Center	(805) 474-2052
<input type="checkbox"/>	4. Community Health Centers	(805) 346-3972	<input type="checkbox"/>	DSS - North County Job Center	(805) 237-3007
<input type="checkbox"/>	5. Cuesta College Programs		<input type="checkbox"/>	Eckerd	888-279-5655
<input type="checkbox"/>	CalWORKs	(805) 546-3970	<input type="checkbox"/>	16. Mental Health (MH)	(805) 781-1177
<input type="checkbox"/>	Foster Kinship Care Education (FKCE)	(805) 546-3970	<input type="checkbox"/>	Martha's Place	(805) 781-4962
<input type="checkbox"/>	6. Department of Rehabilitation	(805) 542-4682	<input type="checkbox"/>	Probation (Adult)	(805) 781-1231
<input type="checkbox"/>	7. Department of Social Services		<input type="checkbox"/>	17. Probation Youth	(805) 781-1169
<input type="checkbox"/>	Adult Services	(805) 788-2834	<input type="checkbox"/>	18. Public Health (PH)	(805) 781-5543
<input type="checkbox"/>	Child Welfare Services	(805) 781-1701	<input type="checkbox"/>	Tobacco Control	(805) 781-1235
<input type="checkbox"/>	Participant Services	(805) 781-1686	<input type="checkbox"/>	19. RISE	(805) 226-5401
<input type="checkbox"/>	8. Drug and Alcohol Services (DAS)	(805) 781-1405	<input type="checkbox"/>	20. Stand Strong	(805) 781-6410
<input type="checkbox"/>	9. Family Resource Centers		<input type="checkbox"/>	21. School Districts	
<input type="checkbox"/>	San Luis Obispo/Coastal/Central	(805) 543-6567	<input type="checkbox"/>	Atascadero	(805) 462-4421
<input type="checkbox"/>	South County SAFE	(805) 474-2025	<input type="checkbox"/>	Paso Robles	(805) 237-3339
<input type="checkbox"/>	The LINK - Atascadero	(805) 462-8901	<input type="checkbox"/>	Templeton	(805) 434-1473
<input type="checkbox"/>	The LINK - Paso Robles	(805) 226-5437	<input type="checkbox"/>	LMUSD	(805) 473-1587
<input type="checkbox"/>	10. Foster Family Agencies		<input type="checkbox"/>	SLCUSD	(805) 543-6567
<input type="checkbox"/>	Aspiranet	(805) 473-3312	<input type="checkbox"/>	22. SLO County Office of Ed. (SLOCOE)	(805) 541-1105
<input type="checkbox"/>	Family Care Network, Inc	(805) 503-6499	<input type="checkbox"/>	23. Transitions-Mental Health Assoc. (T-MHA)	(805) 540-6501
<input type="checkbox"/>	Family Connections Christian Adoptions	(805) 542-9285	<input type="checkbox"/>	24. Tri-Counties Regional Center	(805) 543-8725
<input type="checkbox"/>	Kinship Center	(805) 434-3839	<input type="checkbox"/>	25. Veterans Services of SLO	(805) 781-5769
<input type="checkbox"/>	11. HASLO (Housing Authority of SLO)	(805) 543-4992	<input type="checkbox"/>	26. Victim Witness Assistance (DA)	(805) 781-5828
<input type="checkbox"/>	12. Homeless Services		<input type="checkbox"/>	27. Other:	
<input type="checkbox"/>	5-Cities Homeless Coalition	(805) 668-2380	<input type="checkbox"/>	28. Other:	
<input type="checkbox"/>	Housing Support Program (HSP)	(805) 781-1866	<input type="checkbox"/>	29. Other:	
<input type="checkbox"/>	CAPSLO Case Management	(805) 473-8349	<input type="checkbox"/>	30. Other:	

Federal Reg Title 42: This Information has been disclosed to you from records that are confidential and protected by Federal Law. Federal regulations (42 code of Federal Regs, 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 bbenassi@co.slo.ca.us.

Additional Comments:

NOTE: Please do not place any protected information this area. Protected information should be send as a separate document addressed directly to the intended recipient. This section is to communicate general information regarding the referral of the client.

Date:	Last Name:	First Name:	Middle Initial:
Address:		City/State:	Zip Code:
Home Number:	Cellular:	Ok to Leave Message: Choose	Language Choose:
Parent/Guardian:		Case Type: Choose:	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.

TREATMENT PROVIDERS – YOU DO NOT NEED AN INDIVIDUAL’S NAME TO SHARE HEALTH CARE AND PERSONAL INFORMATION (PHI) WITH TREATMENT PROVIDERS

Initial Here	County of SLO Public Health Department	Initial Here	County of SLO Mental Health Services
Initial Here	CenCal Health	Initial Here	Transitions-Mental Health Association(T-MHA)
Initial Here	Community Health Centers (CHC)	Initial Here	Hospital: Choose:
Initial Here	County of SLO Drug and Alcohol Services (DAS)	Initial Here	Other:

NON-TREATMENT PROVIDERS – YOU MUST HAVE AN INDIVIDUAL’S NAME TO SHARE HEALTH CARE AND PERSONAL INFORMATION (PHI) FROM DRUG AND ALCOHOL PROGRAM

Initial Here	County of SLO Probation Department	Initial Here	Names
Initial Here	Dept. of Social Services: Choose:	Initial Here	Names
Initial Here	CAPSLO: Choose:	Initial Here	Names
Initial Here	Tri-Counties Regional Center (TCRC)	Initial Here	Names
Initial Here	Foster Family Agency: Choose:	Initial Here	Names
Initial Here	Department of Rehabilitation	Initial Here	Names
Initial Here	Family Resource Centers: Choose:	Initial Here	Names
Initial Here	Victim/Witness Program – County SLO D.A.	Initial Here	Names
Initial Here	Veterans Services Department – County of SLO	Initial Here	Names
Initial Here	SLO County Office of Education (SLOCOE)	Initial Here	Names
Initial Here	Allan Hancock EOPS/CalWORKs	Initial Here	Names
Initial Here	Cuesta College: Choose:	Initial Here	Names
Initial Here	School District: Choose:	Initial Here	Names
Initial Here	Stand Strong	Initial Here	Names
Initial Here	HASLO (Housing Authority of SLO)	Initial Here	Names
Initial Here	Homeless Services: Choose:	Initial Here	Names
Initial Here	Independent Living Program (ILP)	Initial Here	Names
Initial Here	RISE	Initial Here	Names
Initial Here	Job Centers: Choose:	Initial Here	Names
Initial Here	Other:	Initial Here	Names
Initial Here	Other:	Initial Here	Names

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

NOTE: THIS AUTHORIZATION FORM ALLOWS DISCLOSURE OF ALL YOUTH 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 health healthcare records or personal records of the person 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 mental 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:

- | | |
|--|--|
| <input checked="" type="checkbox"/> Drug and Alcohol Test Results | <input checked="" type="checkbox"/> Substance Use Diagnosis |
| <input checked="" type="checkbox"/> Drug and Alcohol Treatment Plan | <input checked="" type="checkbox"/> Drug and Alcohol Program Attendance |
| <input checked="" type="checkbox"/> Drug and Alcohol Payment Information | <input checked="" type="checkbox"/> 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 identified 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 am allowed 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 (HIPAA), 45 C.F.R. Pts. 160 and 164, and cannot be re-disclosed without my written consent unless otherwise provided for in the regulations.

Employee Name:	Organization filling out this form:	Date:
Client Signature:	Print Name:	Date:
Representative Signature:	Relation:	Date:

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 individuals:

Initial Here	Name of Person:		Name of Agency:	
Initial Here	Name of Person:		Name of Agency:	
Initial Here	Name of Person:		Name of Agency:	
Initial Here	Name of Person:		Name of Agency:	
Initial Here	Name of Person:		Name of Agency:	
Initial Here	Name of Person:		Name of Agency:	
Initial Here	Name of Person:		Name of Agency:	
Initial Here	Name of Person:		Name of Agency:	
Initial Here	Name of Person:		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.

Employee Name:	Organization filling out this form:	Date:
Client Signature:	Print Name:	Date:
Representative Signature:	Relation:	Date: