



**SUBSTANCE ABUSE PREVENTION AND CONTROL**

**RELEASE OF INFORMATION – IN SAPC SUD PROVIDER NETWORK**

**I. PATIENT INFORMATION**

Name (Last, First, and Middle):	Date of Birth:	Medi-Cal # or My Health LA #:
Address:		Phone Number:

**II. ENTITIES WHO MAY SHARE HEALTH INFORMATION**

**Option 1 – All Providers within the SAPC Provider Network**

I authorize all previous, current, and future providers within Substance Abuse Prevention and Control’s (SAPC) Provider Network to have access to and share my protected health information with each other for the purpose of coordinating my care, substance use disorder (SUD) treatment, non-medical services, and/or benefits acquisition. SAPC and its Provider Network will have access to SAPC's electronic health record database that contains my electronic health information. I understand that the full provider list is included in the Addendum below and is subject to change, and that a current list is available on SAPC’s online Provider Directory at <http://sapccis.ph.lacounty.gov/sbat/>.

**Option 2 – Select Providers within the SAPC Provider Network**

I authorize the following entities to share my protected health information with each other for the purpose of coordinating my care, substance use disorder (SUD) treatment, non-medical services, and/or benefits acquisition. *(Please enter ALL names of SAPC provider organizations/agencies participating in the exchange of protected health information):*

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**III. SCOPE OF DISCLOSURE**

I permit the entities listed in Section II to share the protected health information specified below. Disclosure shall be limited to the following information:

- |                                                                                                 |                                                      |
|-------------------------------------------------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> <u>ALL</u> information listed here in Section III                      | <input type="checkbox"/> Drug test results           |
| <input type="checkbox"/> Assessment information                                                 | <input type="checkbox"/> Laboratory test results     |
| <input type="checkbox"/> Case management/care coordination                                      | <input type="checkbox"/> Medications                 |
| <input type="checkbox"/> Treatment plans                                                        | <input type="checkbox"/> HIV/AIDS test information   |
| <input type="checkbox"/> Progress notes                                                         | <input type="checkbox"/> Discharge plans / summaries |
| <input type="checkbox"/> Health records (primary care, sexual and/or reproductive health, etc.) | <input type="checkbox"/> Mental health records       |
| <input type="checkbox"/> Other (specify): _____                                                 |                                                      |

#### IV. EXPIRATION OF AUTHORIZATION

This Authorization will automatically expire on \_\_\_\_/\_\_\_\_/\_\_\_\_, or one year from date of execution of this Release, whichever is later.

#### V. OTHER IMPORTANT INFORMATION

By signing this Authorization, I understand that:

- 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 provided for by the regulations.
- This Authorization is voluntary and I do not need to sign this Authorization in order to receive treatment, enroll in services, or for payment for my health care.
- I have a right to receive a copy of this Authorization. A copy of this Authorization is as valid as the original.
- If information related to alcohol, drug, or HIV/AIDS treatment is shared, that information cannot be re-disclosed except with another Authorization.
- I have the right to revoke this Authorization at any time in writing unless the entity disclosing my health information already shared my information before receiving my revocation. I may use the Revocation of Authorization at the bottom of this form to terminate this Authorization and may mail or deliver the revocation to SAPC (see mailing address below) or my substance use treatment provider.

**Once my Revocation of Authorization is received, SAPC and/or my provider will cancel the Authorization and notify all involved parties of its cancellation.**

#### VI. SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

I have read and understand the content of this Authorization. I am signing the Authorization voluntarily and understand that I have the right to refuse to sign this document. My signature authorizes the disclosure of the health information as described in Section III of this Authorization.

**Name and Signature of Patient or Patient’s Legal Representative:**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Print Name Signature Month Day Year

**If signed by Patient’s Legal Representative, state relationship and authority to do so:**

\_\_\_\_\_

**Witness: Name and Signature of Providers or Agency/Clinic Representative:**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Print Name and Title Signature Month Day Year

\_\_\_\_\_  
Network Provider Address



## ADDENDUM

Below is an alphabetical list of substance use disorder (SUD) providers within the SAPC Provider Network who are authorized to share health information, as referenced in the above Authorization form. Please circle the relevant SUD providers and enter the other health providers below who will be exchanging health information with this document.

**Other Providers (if applicable):**

- |          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

**Substance Use Disorder Providers:**

The list of SAPC’s substance use provider network below is valid as of 07/18/19.

Please visit SAPC’s online Provider Directory at <http://sapccis.ph.lacounty.gov/sbat/> for the most current list of providers.

ADDICTION RESEARCH AND TREATMENT, INC.	CENTER FOR INTEGRATED FAMILY AND HEALTH SERVICES	ELDORADO COMMUNITY SERVICE CENTER
AEGIS TREATMENT CENTERS, LLC	CHABAD OF CALIFORNIA, INC.	ETTIE LEE HOMES, INCORPORATED
ALCOHOLISM CENTER FOR WOMEN, INC.	CHILD AND FAMILY CENTER	EXODUS RECOVERY INC
AMERICAN HEALTH SERVICES LLC	CHILDREN'S HOSPITAL LOS ANGELES	FAMILIES FOR CHILDREN, INC.
AMERICAN INDIAN CHANGING SPIRITS	CITY OF PASADENA PUBLIC HEALTH DEPARTMENT	FRED BROWN'S RECOVERY SERVICES, INC.
ASIAN AMERICAN DRUG ABUSE PROGRAM, INC.	CLARE FOUNDATION, INC.	GRANDVIEW FOUNDATION, INC.
BEACON HOUSE ASSOCIATION OF SAN PEDRO (THE)	CLINICA MONSEÑOR OSCAR A. ROMERO	HEALTHRIGHT 360
BEHAVIORAL HEALTH SERVICES, INC.	CRI-HELP, INC.	HELPLINE YOUTH COUNSELING, INC.
BEIT T'SHUVAH	DIDI HIRSCH PSYCHIATRIC SERVICE	HOMELESS HEALTH CARE LOS ANGELES, INC.
BIENESTAR HUMAN SERVICES, INC	DIVINE HEALTHCARE SERVICES, INC.	HOUSE OF HOPE FOUNDATION, INC.
CALIFORNIA HISPANIC COMMISSION ON ALCOHOL AND DRUG ABUSE, INC.	EGGLESTON YOUTH CENTERS, INC., D. B. A. EGGLESTON SUBSTANCE ABUSE AND EDUCATION PROGRAM	I-ADARP, INC.
CAMBODIAN ASSOCIATION OF AMERICA	EL PROYECTO DEL BARRIO	JWCH INSTITUTE, INC.
CANON HUMAN SERVICES, INC.		KOREATOWN YOUTH AND COMMUNITY CENTER, INC.

LITTLE HOUSE
LOS ANGELES BIOMEDICAL RESEARCH INSTITUTE AT HARBOR-UCLA MEDICAL CENTER
LOS ANGELES CENTERS FOR ALCOHOL AND DRUG ABUSE
MATRIX INSTITUTE ON ADDICTIONS
MELA COUNSELING SERVICES CENTER, INC.
MOTIVATIONAL RECOVERY SERVICES, INC.
NARCOTIC ADDICTION TREATMENT AGENCY, INC.
NARCOTIC PREVENTION ASSOCIATION, INC.
NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE OF EAST SAN GABRIEL AND POMONA VALLEYS, INC.
NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE OF THE SAN FERNANDO VALLEY
NEW HOPE DRUG & ALCOHOL TREATMENT PROGRAM, INC.
PALM HOUSE, INC.

PENNY LANE CENTERS
PEOPLE COORDINATED SERVICES OF SOUTHERN CALIFORNIA
PHOENIX HOUSES OF LOS ANGELES, INC.
PRINCIPLES, INC.
SAFE REFUGE
SAN FERNANDO VALLEY COMMUNITY MENTAL HEALTH CENTER, INC.
SHIELDS FOR FAMILIES, INC.
SOCIAL MODEL RECOVERY SYSTEMS, INC.
SOUTHERN CALIFORNIA ALCOHOL AND DRUG PROGRAMS, INC.
SPECIAL SERVICE FOR GROUPS, INC.
SPIRITT FAMILY SERVICES
TARZANA TREATMENT CENTERS, INC.
TAVARUA HEALTH SERVICES
TAVARUA MEDICAL REHABILITATION SERVICES D.B.A. AZUSA

MEDICAL AND MENTAL HEALTH SERVICES
THE SALVATION ARMY, A CALIFORNIA CORPORATION
THE TEEN PROJECT, INC., D.B.A. FREEHAB
TRANSCULTURAL HEALTH DEVELOPMENT, INC.
TWIN TOWN CORPORATION
VALLEY WOMEN'S CENTER, INC.
VAN NESS RECOVERY HOUSE
VOLUNTEERS OF AMERICA OF LOS ANGELES
WATTS HEALTHCARE CORPORATION, D.B.A. HOUSE OF UHURU
WEST COUNTY MEDICAL CLINIC
WEST COUNTY MEDICAL CORPORATION
WESTERN PACIFIC MED-CORP
YOU CAN HEALTH SERVICES