

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.

Client Name: _____

Tehama County System of Care

CRIMINAL JUSTICE

EDUCATION

- _____ Tehama County Probation Dept.
- _____ Tehama County Sheriff's Dept.
- _____ Red Bluff Police Dept.
- _____ Corning Police Dept.
- _____ California Dept. Of Corrections,
Parole Division

- _____ 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: _____

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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 Non-Medical 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: _____

<u>Tehama County Health Services Agency</u>	<u>Other Health Care</u>	<u>Criminal Justice</u>
____ 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
<u>Education</u>	<u>Social Services</u>	
____ 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.