AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH AND SOCIAL SERVICE INFORMATION (ADULT)

ZACK THOMAS | 10889 | 02/14/1980
CLIENT NAME | CLIENT ID | DATE OF BIRTH:

The County of Los Angeles ("County") operates and engages in health information exchanges to allow your information to be shared among and between County Programs and their partners to help you get resources and social services that can improve your health. A health information exchange is an electronic system that allows organizations to share information.

"County Programs" are programs that provide services to you or obtain benefits for you through the following County Departments:

- Department of Health Services (DHS)
- Department of Mental Health (DMH)
- Department of Public Health (DPH), including the Substance Abuse Prevention and Control (DPH-SAPC)
- Department of Public Social Services (DPSS)
- Justice, Care and Opportunities Department, only for re-entry services

Many types of organizations work as partners of County Programs, some as contractors or subcontractors, to provide, coordinate, or pay for these services or benefits, including:

- Health care providers
- Mental health providers
- Substance use disorder providers
- Social service providers
- Managed care plans
- Housing and assisted living providers
- Meal service providers
- Legal providers who assist you in obtaining benefits or services
- Community organizations that provide or coordinate services, including to persons involved with the justice system

These organizations may need to share your health and/or social services information to:

- See if you are eligible for services or benefits provided by County Programs or through other resources and/or for Medi-Cal enrollment and benefits
- Coordinate your health care and community supports
- Communicate with your treating providers and organizations and social service providers
- Provide you with treatment and related services
- Receive payment for services
- Conduct quality improvement, reporting, and evaluation activities
- Carry out related County Program activities

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By signing my name below, I agree that my current, past, and future treating providers, non-treating providers listed in Attachment A, and County Programs may disclose my health information, records, social services information, and related data to any County health information exchange. Such data may be used and shared among and between the County Programs. I also agree that County Programs may disclose this information to my current, past, and future treating providers (including County Program subcontractors), and the managed care plans and other organizations that work with County Programs that are listed in Attachment A for the purposes described above.

- I authorize my health and social service information to be shared through any health information exchange operated by or with participation from the County.
- Information that may be shared will include:
  - My general information, such as my age and gender;
  - My medical, mental health, or substance use history;
  - My social service information (including CalFresh, Special Supplemental Nutrition Program for Women, Infants, and Children ("WIC"), General Relief, CalWorks, Cash Assistance P... System/Housing R... nd
  - T...
- I under... e from County Progra...
- I understand that my information will be shared in electronic formats, including through a health information exchange, as described above. My information may also be shared in verbal and written formats.

FULL CONSENT

I specifically authorize my current, past, and future treating providers and County Programs to share the following sensitive information (check as appropriate):

☒ Information from health care providers about my mental health diagnosis or treatment that is protected under Welfare and Institutions Code § 5328 ZT (initial) (excluding psychotherapy notes)

☒ Information from substance use disorder programs (includes substance use disorder diagnoses and medications, inpatient stays and outpatient visits or residential treatment, provider names and contact information, and names of the treatment programs) that is protected under 42 C.F.R. Part 2 or State law ZT (initial)

I may ask for a list of providers and organizations that have received my substance use disorder information by contacting my care manager.

PATIENT HIM LABEL

APPROVED FOR USE AT ALL DHS FACILITIES
SCAN INTO ELECTRONIC HEALTH RECORD

AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH AND SOCIAL SERVICE INFORMATION (ADULT)

I have read this Authorization or it has been read to me. I authorize the use and sharing of my health and social services information as described above.

ZACK THOMAS
CLIENT NAME

[signature]
CLIENT OR RESPONSIBLE PERSON SIGNATURE

05/05/2024
DATE

If this Authorization is signed by a person other than the client, please indicate the relationship:

NAME RELATIONSHIP TO CLIENT

PATIENT HIM LABEL

APPROVED FOR USE AT ALL DHS FACILITIES
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AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH AND SOCIAL SERVICE INFORMATION (ADULT)

I also authorize County Programs to share my health and social service information with the following family members or other persons so that they may assist in coordinating or paying for my care:

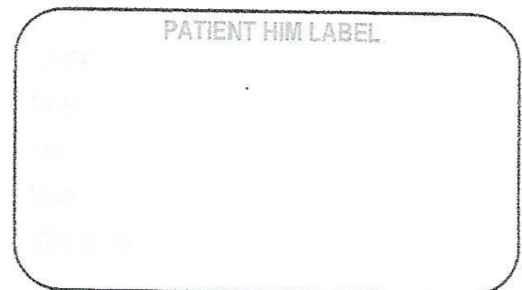
NAME	RELATIONSHIP
EARL EDGAR	BROTHER

(Please continue on back of form if more room is needed.)

I understand:

- This Authorization will be valid for as long as I receive services from County Programs.
- I have the right to cancel or change this Authorization at any time. I can start this process by talking to my service provider or case/care manager. At that time, I will either cancel my Authorization or complete a new Authorization to reflect the change(s) to the sensitive information that I want to share. If I limit my information sharing, my sensitive information will not be shared from that date forward. Any sensitive information previously shared cannot be recalled. Should I elect not to share any sensitive information, certain care coordination, case management, benefits advocacy or other services may be limited, if my authorization is required by Federal law.
- State and Federal laws already allow health care organizations to share some of my health information (including sensitive information) to treat me, obtain payment, and run their operations without my consent. I understand that this Authorization does not change the information that can be shared under these laws. I also understand that my authorization is required to share my substance use disorder information, if applicable.
- When my information is shared, Federal law or California privacy law may not protect the re-sharing of my information, except for substance use disorder information that is specially protected and may not be re-shared with others.
- My ability to receive medical services, treatment, or public social services does not depend upon whether I sign this Authorization. However, if I choose not to sign this Authorization, County Programs may not be able to share data to coordinate the services I receive, and I may not be able to receive full care coordination, case management, benefits advocacy or related services.
- I have the right to:
    - Inspect or obtain a copy of my health information and social services information that is shared by this Authorization.
    - Refuse to sign this Authorization.
    - Receive a copy of this Authorization.

[*signature on following page*]



Attachment A
Non-Treating Providers (for Payment, Benefits Advocacy, etc.)

Health Plans, Federal, State and Local Organizations

- Anthem Blue Cross/Care
- Health Net
- Blue Shield Promise
- LA Care
- Molina Health Care
- Kaiser Permanente
- Senior Care Action Network (SCAN)
- U.S. Social Security Administration Disability Determination Services
- U.S. Veteran's Administration
- Centers for Medicare and Medicaid Services
- California Department of Health Care Services
- California Department of Social Services
- California Department of Developmental Services
- LA Homeless Services Authority
- LA County Department of Children and Family Services
- LA County Department of Military and Veterans Affair
- LA Cash Assistance for Immigrants Program (CAPI)

CBEST Participant Organizations (Benefits Advocacy)

- Inner City Law Center
- Legal Aid Foundation of Los Angeles (LAFLA)
- Health Advocates
- Lutheran Social Services
- Los Angeles County Department of Consumer and Business Affairs
- Special Services for Groups
- St. Joseph's Center
- Tarzana Treatment Center
- The Catalyst Foundation
- Volunteers of America
- Watts Community Action Labor Committee (WLCAC)

PATIENT HIM LABEL

I revoke the Authorization submitted to County Programs as ______________________________
DATE

This Revocation does not affect any disclosures made prior to receiving this Revocation. This Revocation does not change the information that may be shared under State or federal laws without my consent.

____
CLIENT NAME

____ ______________________
CLIENT OR RESPONSIBLE PERSON SIGNATURE DATE

If this Authorization is signed by a person other than the client, please indicate the relationship:

____
NAME RELATIONSHIP TO CLIENT

PATIENT HIM LABEL
NAME
DOB
FIN#
MR#
SEX on ID