Authorization for the Sonoma County Multi-Disciplinary Team to Share and Use Information

Rev. 03/01/20

Client's Legal Name: _____ DOB _____

Also Known As (Optional Alt Name): _____ Last 4 SSN Digits [ ][ ][ ][ ]

Sonoma County coordinates teams of health care providers, substance use services, social service agencies, homeless services, and public safety agencies to help clients get the services they need. By signing this form, you will allow these teams, and the individuals who are part of them, to share your health and other information so that they can provide you services and help you get better results. The teams who will be allowed to see and share your information will include individuals from some or all of the Sonoma County agencies and organizations listed below. If you choose not to share your information, you will still be able to seek services from these organizations on your own, but you will not be eligible for extra help from the Sonoma County Multi-Disciplinary Team.

AUTHORIZATION TO DISCLOSE AND EXCHANGE MY HEALTH AND PERSONAL INFORMATION

Initial Here	INITIAL HERE TO ALLOW ALL AGENCIES LISTED BELOW TO SHARE YOUR INFORMATION: I've written my initials to acknowledge that the County agencies, health care providers, and other organizations listed below are allowed to share my information with each other. I understand that I don't have to sign this form if I don't want to.

Sonoma County Departments:

Health Services
- Drug & Alcohol Services
- Mental Health Services
- Public Health

Human Services
- Adult and Aging including Veterans Services
- Economic Assistance
- Employment & Training
- Family, Youth and Children Services

Housing and Homelessness Services (CDC)
Probation Department
Child Support Services
Public Defender's Office
Sonoma County Sheriff's Office

Other Agencies: (Community Partners)

Community Health Services
- Alliance Medical Center
- Petaluma Health Center
- Santa Rosa Community Health Centers
- West County Health Centers
- Sonoma Valley Community Health Centers
- Alexander Valley Health Care
- Sonoma County Indian Health Project

Hospital Systems
- St. Joseph Health System and clinics
- Kaiser Permanente Hospitals and clinics
- Sutter Hospitals and clinics
- Sonoma Valley Hospital and clinics
- Healdsburg District Hospital and clinics

Other Service Agencies
- Goodwill Industries
- Community Action Partnership
- North Bay Regional Center
- Legal Aid of Sonoma County
- Redwood Community Health Coalition
- Partnership Health Plan
- Family Justice Center
- Face to Face HIV Services

Homeless Services Agencies
- Catholic Charities of Santa Rosa
- Committee on the Shelterless - COTS
- Redwood Gospel Mission
- Interlink Self-Help Center
- Buckelew Programs
- West County Community Services
- Interfaith Shelter Network
- Sonoma Overnight Support
- Social Advocates Network
- The Living Room
- Reach for Home
- St. Vincent de Paul

Substance Use Disorder Services
- Drug Abuse Alternative Center
- Turning Point Residential Treatment
- Petaluma Sober Circle
- California Human Development
- Women's Recovery Services

Youth Services
- Child Parent Institute
- Early Learning Institute
- Head Start
- Community Child Care Council of Sonoma
- Social Advocates for Youth (SAY)

Other: _____

Other: _____

Other: _____

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This authorization to release information will **expire 5 years from the date it is signed; or will expire on:_____** ***(Not to exceed 5 Years.)***

HEALTH AND PERSONAL INFORMATION THAT CAN BE SHARED BY THE IDENTIFIED AGENCIES

THIS AUTHORIZATION ALLOWS DISCLOSURE OF ALL YOUR HEALTH, SOCIAL SERVICES, AND PROBATION RECORDS

The agencies listed on this authorization form can share any and all information from your health care records or personal records. The information may come from your past, present or future physical health provider, mental health provider, or substance use treatment provider. The information may also come from your Social Services records, Justice Records (if any) or the records of any other agency listed on this authorization form. The information the agencies share may be written or spoken.

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 <u>past 5 years</u> of Substance Use Program information from past, present and future treating providers.**

Initial Here **Initial here to indicate you understand we will share your HIV/Aids information.**

PURPOSES AND LIMITATIONS ON THE USE OF YOUR HEALTH AND PERSONAL INFORMATION

The agencies listed on this authorization form will use the information they share to refer you to services or to work with other agencies to improve your health and well-being. These services may be in areas like health care, housing, employment, education, nutrition, parenting, child welfare, and/or other traditional social services. This information may also be used for research purposes.

I understand that:

- I have a right to receive a copy of this authorization and have been offered a copy.
- I have the right to tell you to stop sharing my information. I can tell you, or I can write a letter to:
  Sonoma County Privacy Officer: 1450 Neotomas Ave, Santa Rosa, CA, 95405
  or by e-mail at DHS-Privacy&Security@Sonoma-County.org; or call (707) 565-5703

If I tell you to stop sharing my information, you will stop on the day I tell you to stop, but it will not affect information you already shared.

- I understand I don't have to sign this form and my information won't be shared if I don't sign it. The County won't deny me treatment, enrollment, or eligibility for benefits if I don't sign this form; however, some services and treatment won't happen if I don't allow my information to be shared.
- Information that the agencies share with each other may then be shared by the person who gets the information, except for certain federally protected drug and alcohol records. I understand that some of the information that is shared may no longer be protected by privacy laws; for example if I allow information to be shared with a family member.

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