County of Sacramento Department of Health Services Division of Behavioral Health Services Policy and Procedure	Policy Issuer (Unit/Program)	**SUPT**
	Policy Number	**SUPT-10-01**
	Effective Date	**12-30-2009**
	Revision Date	**07-29-2020**
Title: Confidentiality and Release of Client Information	Functional Area: Quality Management	
Approved By: (Signature on File) **Signed version available upon request** **Lori Miller, LCSW** Division Manager, Substance Use Prevention and Treatment Services		

BACKGROUND/CONTEXT:

Sacramento County Substance Use Prevention and Treatment Services (SUPT) is mandated by Title 42 of the Code of Federal Regulations (CFR) Part 2 – Confidentiality of Substance Use Disorder Patient Records and Health Insurance Portability and Accountability Act (HIPAA) of 1996, to protect the confidentiality of its clients. This includes, but is not limited to, clinical information, billing and financial information, and demographic/scheduling information.

All client information obtained by SUPT staff, including the fact that the client is participating in a SUPT program or being assessed to participate, is considered confidential. SUPT staff are prohibited by law from disclosing confidential information to a third party without the written consent of the client, or as provided by law as set forth in 42 CFR Part 2 or the applicable HIPAA provisions. When SUPT staff are legally authorized to disclose confidential information, they only disclose the minimum amount of information needed to address the purpose for the release of information.

SUPT monitors contracted providers to ensure compliance with Program Specifications and Confidentiality requirements as outlined in the County of Sacramento Intergovernmental Agreement (IA) between SUPT and the State of California Department of Health Care Services (DHCS). As such, contracted providers use and disclose such individually identifiable health information in accordance with the privacy requirements in 45 CFR Parts 160 and 164, subparts A and E, and 42 CFR Part 2, to the extent that these requirements are applicable.

SUPT staff have a legal obligation to respond to subpoenas requesting client records. SUPT complies with Privacy and Information Security Provisions and follows guidelines for privacy and security obligations set forth in the IA, which includes mandates that compel SUPT staff to make use or disclosure of Protected Health Information (PHI) that is enforceable in a court of law.

DEFINITIONS:

- **Client:** any individual, family, consumer or resident for whom SUPT provides services, including those persons requesting information or an assessment for services.

- **Record:** all written or electronic records concerning a client including, without limitation, any and all information that may be contained in a client's treatment, blling, or other record.

- **Staff:** professional, para-professional or support staff who is providing services to the client, including volunteers and student trainees or interns enrolled in an educational program requiring clinical field experience prior to the receipt of a degree in psychology, professional counseling or social work.

- **Protected Health Information (PHI):** an individual's health/medical information (including payment for healthcare) combined with information that could reasonably identify that individual: personal information, demographic information, and information related to health status, services received or healthcare payment.

- **HIPAA (Health Insurance Portability and Accountability Act):** provides privacy standards to protect clients' medical records and other health information. As a County "covered component" defined in HIPAA and CFR 45, SUPT adheres to the Sacramento County Office of Compliance provisions, including administrative, physical, and technical safeguards to prevent unauthorized use and disclosure of PHI in all formats (written, verbal, and electronic).

- **Subpoena:** A written summons issued by a court to compel testimony by a witness or production of evidence under penalty for failure.

PURPOSE:
The purpose of this policy is to set forth SUPT's commitment to its clients' right to privacy and rights in relation to the use and disclosure of individually identifiable health information under HIPAA and PHI requirements. Client privacy is to be safeguarded by establishing and implementing sound practices and procedures that protect the confidentiality of client records. All employees of SUPT – professional and support staff – as well as interns and volunteers are bound by this policy to protect clients' privacy to the fullest extent allowed by law.

DETAILS:

Policy:
It is the policy of SUPT to implement and maintain arrangements and procedures that effectively and safely respond to requests for client records as required and in accordance with all applicable regulations.

Procedure:

Receiving and Responding to Client Records Requests

A. Informed Consent

1. Client Signatures, Documentation, Consent and Privacy
   a.) Client signatures are required in many situations (i.e. release of information, informed consent, and notice of privacy practices).
   b.) During a public health emergency
      i. Compliance with all applicable privacy laws is required whenever PHI is transferred through a secure electronic signature platform
      ii. If a client signature cannot be obtained, for any reason, the reason for the missing signature must be documented
      iii. Verbal or written consent must be obtained before using telehealth to deliver services
   c.) After a public health emergency
      i. Requirement for signatures will resume
      ii. Signatures must be obtained when they are due
2. Service/Treatment
   a.) All clients have the right to receive a notice telling them how their PHI may be used and disclosed by the County and the County's legal responsibilities to protect their medical information. That notice is the Form 2090 Notice of Privacy Practices (NOPP) brochure.
   b.) Clients are asked to sign the Form 2092 Acknowledgement of Receipt confirming receipt of the NOPP brochure.
   c.) The Form 2092 Acknowledgement of Receipt with client's name, date and signature is placed in the client's chart.

B. Confidentiality of Records

All client records are confidential. Client records shall not be released to any individual or entity except in accordance with written County procedures, including its Notice of Privacy Practices.

1. Client Access to Their Records
   a.) Clients can request a copy or ask for a review of their own records.
   b.) Form 2093 Client Request to Access Records must be completed and signed.
2. Release of Information <u>with</u> Client Authorization
   a.) A written authorization from the client is required for many uses and disclosures.
   b.) Form 2099 Authorization to Obtain or Release PHI must be completed and signed.
   c.) The client has the right to revoke or cancel a signed authorization at any time.
   d.) Form 2099c Authorization to Release Health Records Multi-Disciplinary Team must be completed and signed prior to disclosing confidential client information when working within a multi-disciplinary team.

3. Release of Information without Client Authorization
    a.) The law allows for the disclosure of confidential information without a signed Form 2099 Authorization to Obtain or Release PHI in the following circumstances:
        i. Internal program communications between program personnel having a need of information in connection with their duties that arise out of the provision of assessment, treatment, or referral for treatment
        ii. When federal, state, or local government conduct audits and evaluations required by law
        iii. To file a report of suspected child abuse or elder/dependent adult abuse (*Note: seek supervision before releasing confidential information related to suspected abuse*)
        iv. Medical emergency, including a temporary state of emergency as a result of a natural or major disaster, but only to those medical personnel treating the client
        v. Court order
4. Verification
    a.) Identity of the client must be verified before PHI is released.
    b.) Photo identification is required to verify client identity.
5. Using Personal Devices
    a.) Personal devices should generally not be used to communicate with clients.
    b.) If a patient contacts a staff on their personal device, staff will:
        i. Immediately delete the information from their personal account
        ii. Only respond as authorized by 42 CFR Part 2

C. Use of Records for Research, Training, and Presentations
1. Any client record information used for research, training and presentations will be modified to conceal and remove all PHI.
2. Data may be disclosed to any entity for research purposes as long as the disclosure complies with HIPAA.
3. The Sacramento County Department of Health Services Consent Agreement must be signed and submitted according to instructions on the form in the following circumstances:
    a.) Photographs or video images of client used in any manner including on the internet.
    b.) Client interviews or inclusion of client in media, newsletters, or other distributed materials.
    c.) Creative writing, artwork, thank you notes or other representations of a client's personal story or "Lived Experience".
    d.) Clients who are requested to speak at conferences, events, or media.

D. Record of Disclosure
   1. PHI that is released must be documented on Form 2097 Accounting of Disclosures.
   2. Please refer to the Instructions for Procedures on Form 2097 for disclosures that are to be tracked and accounted for.

Receiving and Responding to Subpoenas

A. Receiving a Subpoena
   1. Subpoenas are submitted to the Front Desk of the Sacramento County Department of Health Services located at 7001-A East Parkway, Sacramento, CA 95823.
   2. Subpoenas related to clients receiving services through SUPT contracted providers will be accepted by any SUPT staff person.
   3. SUPT staff sign for the subpoena upon receipt.

B. Responding to a Subpoena
   1. Upon receipt, SUPT staff will immediately submit the subpoena to the Quality Management Unit of the Sacramento County Behavioral Health Services Division.
   2. SUPT staff will not provide any verbal or written information without direction from Quality Management and County Counsel.
   3. The Quality Management Unit:
      a.) Reviews the subpoena and determines what documents will be provided
      b.) Immediately locates any requested client records or relevant documentation for subsequent review
      c.) Contacts the client's contracted SUPT service providers to obtain signed consent if necessary
      d.) Consults with County Counsel as applicable
   4. SUPT and the Quality Management Unit will follow the direction of County Counsel regarding the release or disclosure of any client information.
   5. The Form 2097 Accounting of Disclosures Form must be completed before releasing any information.
   6. Any release of information shall be limited to what is specifically requested in the subpoena.

REFERENCE(S)/ATTACHMENTS:

- Exhibit A, Attachment I, Program Specifications, County of Sacramento Intergovernmental Agreement
- Exhibit F, Privacy and Information Security Provisions, F-1 HIPAA Business Associate Addendum – County of Sacramento Intergovernmental Agreement
- Title 45 CFR Part 160 and 164 – Privacy Rule
- Title 42 CFR Part 2 – Confidentiality of Substance Use Disorder Patient Records
- California Code, Welfare & Institutions Code – WIC §§ 10850
- Title 9, California Code of Regulations – 1810.440(c)(2)(B)

- Behavioral Health Information Notice No.: 20:009
- Attachment 1: HIPAA Form 2090 – Notice of Privacy Practices (NOPP) Brochure
- Attachment 2: HIPAA Form 2092 – NOPP Acknowledgement of Receipt
- Attachment 3: HIPAA Form 2093 – Client Request to Access Records
- Attachment 4: HIPAA Form 2099 – Authorization to Obtain or Release Protected Health Information
- Attachment 5: HIPAA Form 2099c – Authorization to Release Health Records, Multi-Disciplinary Team (MDT)
- Attachment 6: Sacramento County Department of Health Services Consent Agreement
- Attachment 7: HIPAA Form 2097 – Accounting of Disclosures
- Sacramento County HIPPA Security Rule Policies and Procedures http://inside.compliance.saccounty.net/Documents/HIPAA%20Security%20Rule%20PPs%20Rev%202019.pdf
- Sacramento County Office of Compliance and HIPAA http://inside.compliance.saccounty.net/Pages/default.aspx

RELATED POLICIES:

- No. SUPT-02-03 Responding to Requests for Public Records
- No. SUPT-02-01 Professional Business Standards
- No. QM-03-12 Incident and Breach Notification of Protected Health Information
- No. QM-04-01 Division of Behavioral Health Services Compliance Program

DISTRIBUTION:

Enter X	DL Name	Enter X	DL Name
X	SUPT Administration	**X**	SUPT Prevention Providers
X	SUPT County Counselors	**X**	SUPT Adult Treatment Providers
X	SUPT Collaborative Courts	**X**	SUPT Youth Treatment Providers
X	SUPT System of Care		SUPT Advisory Board
X	SUPT Administrative Support Staff	**X**	SUPT SUD Subcontractors
X	SUPT Options for Recovery		BHS Mental Health Services
X	SUPT Proposition 36	**X**	BHS Quality Management

CONTACT INFORMATION:

Lori Miller, LCSW
MillerLori@saccounty.net

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request in writing. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests. Health plans may request additional information in order to accommodate your request.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, http://www.compliance.saccounty.net. To obtain a paper copy of this notice, contact the Office of Compliance, Phone 1-866-234-6883, or email your request to HIPAAOffice@saccounty.net.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the U.S. Department of Health and Human Services Office for Civil Rights.

To file a complaint with our office, please contact: Office of Compliance, Phone: 1-866-234-6883 or email: HIPAAOffice@saccounty.net.

To download a copy of the Complaint Form from our website:

http://www.compliance.saccounty.net .

All complaints must be made in writing. You will not be penalized for filing a complaint.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our offices that provide health care services. The notice will contain the effective date on the first page, in the top right-hand corner.

*****IMPORTANT*****
A COUNTY OF SACRAMENTO HEALTH PLAN THAT PAYS FOR YOUR MEDICAL CARE BUT DOES NOT PROVIDE THAT CARE DOES NOT HAVE FULL COPIES OF YOUR MEDICAL RECORDS. IF YOU WANT TO LOOK AT, GET A COPY OF, OR CHANGE YOUR MEDICAL RECORDS, PLEASE CONTACT YOUR DOCTOR, DENTIST, OR CLINIC.

Form 2090
County of Sacramento NOPP
Eff. 09-23-13, rev. 01-10-17

Effective September 23, 2013

Notice of Privacy Practices

For County of Sacramento health care providers and health care plans

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Notify you following a breach of your unsecured protected health information
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

<u>USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO AGREE OR OBJECT</u>

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever it is practicable to do so.

<u>YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES</u>

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

<u>YOUR RIGHTS</u>:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Medical Record Number

Patient Name (MUST BE COMPLETED)

Addressograph or Label – Patient Name, Medical Record Number

COUNTY OF SACRAMENTO

(Type Program Name And Address Information Below)

NOTICE OF PRIVACY PRACTICES
Acknowledgement of Receipt

Effective Date: September 23, 2013

The Notice of Privacy Practices tells you how the County of Sacramento may use or disclose protected health information about you. We encourage you to read it in full. Not all situations will be described. You may ask questions about the Notice of Privacy Practices. Your signature below acknowledges your receipt of the Notice.

Signature: _____ Date: _____

Patient, Parent or Personal Representative *(MM/DD/YYYY)*

If other than the patient, specify relationship: _____

FOR COUNTY USE ONLY: INABILITY TO OBTAIN ACKNOWLEDGEMENT

If the County is not able to obtain the patient's acknowledgement, record the good-faith effort made to obtain acknowledgement, and the reason acknowledgement was not obtained:

Reason acknowledgement was not obtained:

- ☐ Patient refused to sign
- ☐ Patient did not return acknowledgement receipt form
- ☐ Other, please describe below:

_____

Effort to obtain acknowledgement:

- ☐ In-person request
- ☐ Request via mail (send copy of letter to EMR for inclusion in patient's record)
- ☐ Other, please describe below:

_____

County Staff: _____ _____ _____

Signature *Print Name* *Date (MM/DD/YYYY)*

INSTRUCTIONS: Please have this document completed and signed by the individual receiving the Notice of Privacy Practices. Provide one copy to the individual. File the original in the medical record under "HIPAA".

County of Sacramento
CLIENT REQUEST TO ACCESS HEALTH RECORDS

PROGRAM NAME AND CONTACT INFORMATION:

Client Name (First, Middle, Last): ***Print Neatly***	
Date of Birth:	**Record #:**
Address:	
City/State/Zip Code:	
Phone #:	
Email (Optional-For questions only)	

RELEASE (disclose) your Protected Health Information to (check one box):

☐ Third Party as Requested by Client — **Complete Recipient Section below:**
☐ Self (Client as shown above)
☐ Personal Representative (see signature box)

Recipient Name:	
Address:	
City/State/Zip Code:	
Phone #:	**Fax #:**

INFORMATION TO BE RELEASED:

☐ All Medical Records *(Except Mental Health, Alcohol/Drug or HIV unless indicated in next section)*
☐ Lab Tests
☐ Medication
☐ Treatment/Personal Service Plan
☐ Discharge Summary
☐ Social History
☐ Attendance Only Records
☐ Consultation Reports/Physician Order
☐ Progress Reports/Notes
☐ Psychiatric/Psychological Assessment/Testing Results
☐ Billing or Payment Information
☐ Records from a specific visit or hospitalization (Enter date and location): _____
☐ Other (Must describe): _____

NOTE: Records relating to mental health, or alcohol/drug departments, or results of HIV antibody tests are specifically protected, and will not be disclosed unless you sign below:

☐ Mental Health records	**Signature**:
☐ Alcohol/Drug dependency treatment records	**Signature**:
☐ HIV antibody test results	**Signature**:

I understand that I have a right to a signed copy of this authorization.

Client's Signature	**Printed Name**	**Date**

Personal Representative's Signature	**Printed Name**	**Date**

Relationship to the Client: (See also VERIFICATION on next page) ☐ Parent ☐ Guardian
☐ Other: Describe _____

INTERNAL USE ONLY:

STAFF PERSON WHO VERIFIED IDENTITY OF THE ABOVE (Print Name):

Request received on (Date):

Request received by (name and location):

Request completed on (Date):

VERIFICATION: We are required to verify you have the authority to sign this form. You will need to provide picture identification, like a California state ID or a California driver's license. (See County HIPAA Privacy Rule Policy and Procedures for other acceptable forms of identification). **You are required to attach a copy of the picture identification or present it in person.**

VERIFICATION for Personal Representative: If the signer is a guardian or legal custodian of an adult, minor, emancipated minor or a representative of a deceased client and is authorized by state law to act on behalf of the individual in making decisions about health care, a copy of the legal authority (guardianship or custody order) must be attached to this form. If the signer is a personal representative that does not have the legal authority, the patient must provide documentation in writing appointing this person as a representative and **this documentation must be attached**.

Your Right to Access Your Information:

- You have a right to request to inspect and/or obtain a copy of your protected health information.
- You have a right to have an answer to your request within 30 days. If the information is not at this location, we may need an additional 30 days to comply with your request. If there are delays in getting you the information, you will be notified in writing.
- You may be charged a fee for copies of your health information.
- Your request may be denied if licensed health professionals involved in your case believe that access to your information could be harmful to you or others or your information was given to County of Sacramento by someone other than a health care provider, under the promise of confidentiality. For some denials, you may have a right to have another licensed health care professional, who was not involved in the original review, review your request.
- County of Sacramento may provide a summary of your health information instead of the actual health information if you agree.

Information Excluded from the Right of Access:

- Psychotherapy notes, which are the personal notes of a mental health care provider documenting or analyzing the contents of a counseling session, that are maintained separate from the rest of the patient's medical record. See 45 CFR 164.524(a)(1)(i) and 164.501.
- Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. See 45 CFR 164.524(a)(1)(ii).

Reference: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/

County of Sacramento

AUTHORIZATION TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION (PHI)

CONTACT:

Client Name (First, Middle, Last): ***Print Neatly***	
Date of Birth:	**Record #:**
Address:	
City/State/Zip Code:	
Phone #: ( )	
Email (Optional-For Contact only)	

☐ **OBTAIN from** (Individual or Entity that has the Protected Health Information)**:**

☐ **RELEASE (disclose)** your Protected Health Information to:

Recipient Name:	
Address:	
City/State/Zip Code:	
Phone #: ( )	**Fax #:** ( )

PURPOSE: The health information disclosed may only be used for the following purpose(s):

INFORMATION TO BE RELEASED:

☐ All Medical Records *(Except Mental Health, Alcohol/Drug or HIV unless indicated in next section)*

☐ Lab Tests	☐ Attendance Only Records
☐ Medication	☐ Consultation Reports/Physician Order
☐ Treatment/Personal Service Plan	☐ Progress Reports/Notes
☐ Discharge Summary	☐ Psychiatric/Psychological Assessment/Testing Results
☐ Social History	☐ Billing or Payment Information

☐ Records from a specific visit or hospitalization (Enter date and location):

☐ Other (Must describe):

NOTE: Records relating to mental health, or alcohol/drug departments, or results of HIV antibody tests are specifically protected, and will not be disclosed unless you sign below:

☐ Mental Health records	**Signature**:
☐ Alcohol/Drug dependency treatment records	**Signature**:
☐ HIV antibody test results	**Signature**:

EXPIRATION: This Authorization will expire on _____/_____/_____ date. (mm/dd/yyyy) *(Must be no more than one year from the date of signature.)*

REVOCATION: You or your personal representative can revoke this authorization at any time upon written request. Revocation will take effect upon receipt, except to the extent that others have acted upon this authorization prior to receipt of the revocation.

REDISCLOSURE: Re-disclosure of these records is not allowed unless another authorization is obtained from you, or such disclosure is specifically required or permitted by federal or state law.

I understand that I have a right to a signed copy of this authorization.

		/ /
Client's Signature	**Printed Name**	**Date**
		/ /
Personal Representative's Signature	**Printed Name**	**Date**

STAFF PERSON WHO VERIFIED IDENTITY OF THE ABOVE (Print Name):

VERIFICATION: We are required to verify you have the authority to sign this form. You will need to provide picture identification, like a California state ID or a California driver's license. (See County HIPAA Privacy Rule Policy and Procedures for other acceptable forms of identification). You are required to attach a copy of the picture identification or present it in person.

VERIFICATION for Personal Representative: If the signer is a guardian or legal custodian of an adult, minor, emancipated minor or a representative of a deceased client and is authorized by state law to act on behalf of the individual in making decisions about health care, a copy of the legal authority (guardianship or custody order) must be attached to this form. If the signer is a personal representative that does not have the legal authority, the patient must provide documentation in writing appointing this person as a representative and this documentation must be attached.

General Medical Records: Re-disclosure of these records is not allowed unless another authorization is obtained from you, or unless such disclosure is specifically required or permitted by federal or state law.

HIV, Alcohol and Drug, and Mental Health Treatment: These records are protected under federal or state law and cannot be disclosed without your written authorization unless otherwise provided. All HIV test information released must be labeled with a statement that: "This information may not be disclosed to any one without the specific written authorization of the individual."

This authorization is voluntary. The client's health information may be protected under federal or state confidentiality laws. These federal or state laws may not apply to the person or organization receiving the information being shared. The client may choose not to sign this authorization and this will not affect their ability to obtain treatment or payment or my current eligibility for health care benefits. However, if this information is necessary to determine if client is eligible to enroll in the Sacramento County Health program, the client may not be able to show they qualify for these services.

(If applicable) Client understands that County of Sacramento has been asked to provide a health care service (such as a test or evaluation) only for the purpose of being able to provide that information to someone else, and if client chooses not to authorize the disclosure of that information to the other person, then County of Sacramento may not provide that health care service to the client.

VALID AUTHORIZATION: THIS AUTHORIZATION IS NOT VALID IF:
The authorization is missing the elements described below:

- A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.
- The name or other specific identification of the person authorized to make the requested use or disclosure.
- The name or other specific identification of the person(s) or class of persons to whom the covered entity may make the requested use or disclosure.
- A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
- A specific expiration date not to exceed one year from the client's signature.
- Signature of the client or client's personal representative and date.

County of Sacramento

Authorization To Release Information To Multidisciplinary Team (MDT)

NAME/ADDRESS/PHONE OF COUNTY PROGRAM:

Client Name (First, Middle, Last): *Print Neatly*	
Date of Birth:	**Record #:**
Address:	
City/State/Zip Code:	
Phone #: ( )	
Other contact info:	

NOTE: Records relating to mental health, or substance use disorder, or results of HIV antibody tests are specifically protected, and <u>will not be disclosed unless you sign below</u>:

☐ Mental Health records	**Signature**:
☐ Substance Use Disorder records	**Signature**:
☐ HIV antibody test results	**Signature**:

INFORMATION TO BE RELEASED (Clearly describe the information that may be disclosed.)

<u>Check all that apply</u>

☐ All Medical Records *(<u>Except</u> Mental Health, Substance Use Disorder or HIV <u>unless indicated in section above</u>)*

☐ Lab Tests
☐ Medication
☐ Treatment/Personal Service Plan
☐ Discharge Summary
☐ Social History
☐ Attendance Only Records
☐ Consultation Reports/Physician Order
☐ Progress Reports/Notes
☐ Psychiatric/Psychological Assessment/Testing Results
☐ Billing or Payment Information

☐ Records from a specific visit or hospitalization (Enter date and location): _____

☐ Other (**<u>Must describe--add sufficient detail)</u>**):

PURPOSE: The information disclosed to the MDT may only be used for the following purpose(s):

I understand that my confidential information indicated above will be discussed or disclosed to the following MDT team members (<u>check only those that apply</u>):

Team Members (list by name or class/role and entity):

☐ _____ ☐ _____
☐ _____ ☐ _____
☐ _____ ☐ _____
☐ _____ ☐ _____

EXPIRATION: This Authorization will expire on ____/____/_____ date. (mm/dd/yyyy) *(Must be no more than one year from the date of signature.)*

- **REVOCATION:** You or your personal representative can revoke this authorization at any time upon written request. Revocation will take effect upon receipt, except to the extent that others have acted upon this authorization prior to receipt of the revocation.
- **REDISCLOSURE:** Re-disclosure of these records is not allowed unless another authorization is obtained from you, <u>or</u> such disclosure is specifically required or permitted by federal or state law.
- **You have the right to receive a signed copy of this authorization.**

		/ /
Client's Signature	**Printed Name**	**Date**
		/ /
Personal Representative's Signature	**Printed Name**	**Date**

STAFF PERSON WHO VERIFIED IDENTITY OF THE ABOVE (Print First & Last Name):

VERIFICATION: We are required to verify you have the authority to sign this form. You will need to provide picture identification, like a California state ID or a California driver's license. (See County HIPAA Privacy Rule Policy and Procedures for other acceptable forms of identification). You are required to attach a copy of the picture identification or present it in person.

VERIFICATION for Personal Representative: If the signer is a guardian or legal custodian of an adult, minor, emancipated minor or a representative of a deceased client and is authorized by state law to act on behalf of the individual in making decisions about health care, a copy of the legal authority (guardianship or custody order) must be attached to this form. If the signer is a personal representative that does not have the legal authority, the patient must provide documentation in writing appointing this person as a representative and this documentation must be attached.

General Medical Records: Re-disclosure of these records is not allowed unless another authorization is obtained from you, or unless such disclosure is specifically required or permitted by federal or state law.

HIV, Substance Use Disorder, and Mental Health Treatment: These records are protected under federal or state law and cannot be disclosed without your written authorization unless otherwise provided. All HIV test information released must be labeled with a statement that: "This information may not be disclosed to any one without the specific written authorization of the individual."

Information in Substance Use Disorder records is protected by federal confidentiality rules (*42 CFR Part 2*). The federal rules prohibit redisclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is *NOT* sufficient for this purpose. The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided by law.

This authorization is voluntary. The client's health information may be protected under federal or state confidentiality laws. These federal or state laws may not apply to the person or organization receiving the information being shared. The client may choose not to sign this authorization and this will not affect their ability to obtain treatment or payment or my current eligibility for health care benefits. However, if this information is necessary to determine if client is eligible to enroll in the Sacramento County Health program, the client may not be able to show they qualify for these services.

(If applicable) Client understands that County of Sacramento has been asked to provide a health care service (such as a test or evaluation) only for the purpose of being able to provide that information to someone else, and if client chooses not to authorize the disclosure of that information to the other person, then County of Sacramento may not provide that health care service to the client.

VALID AUTHORIZATION: THIS AUTHORIZATION IS NOT VALID IF:
The authorization is missing the elements described below:

- A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.
- The name or other specific identification of the person authorized to make the requested use or disclosure.
- The name or other specific identification of the person(s) or class of persons to whom the covered entity may make the requested use or disclosure.
- A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
- A specific expiration date not to exceed one year from the client's signature.
- Signature of the client or client's personal representative and date.

INSTRUCTIONS
for the Multidisciplinary Team Authorization Form 2099c

If a client is NOT part of a designated MDT, use the HIPAA Form 2099 Authorization form.

VERIFICATION: We are required to verify and confirm the client's identity with picture identification, like a California state ID or a California driver's license. (See County HIPAA Privacy Rule Policy and Procedures for other acceptable forms of identification). Attach a copy of the picture identification.

VERIFICATION for Personal Representative: If the signer is a guardian or legal custodian of an adult, minor, emancipated minor or a representative of a deceased patient and is authorized by state law to act on behalf of the individual in making decisions about health care, a copy of the legal authority (guardianship or custody order) must be attached to this form. If the signer is a personal representative that does not have the legal authority, the client must provide documentation in writing appointing this person as a representative and this documentation must be attached.

TEAM MEMBERS: Must identify the team member(s)'s name or class/role and entity. For example, Sacramento County Probation Officer (not Probation Department), Sacramento County CPS Worker (not Child Protective Services), etc. If a new member class/role or name needs to be added, a new authorization must be obtained.

ABOUT THE FORM: This authorization is a **Voluntary Form.** Be sure the individual understands it before signing.

EXPIRATION DATE: The expiration date cannot exceed one year from the client's signature date. In addition, if this release is for an event, please enter the event expiration date.

RIGHT TO REVOKE: The individual has a right to revoke this form. When an individual revokes written authorization to disclose information, the County of Sacramento must boldly mark the authorization form "revoked" and include the date and signature of the requesting individual.

COPY TO THE INDIVIDUAL: We must provide the individual with a copy of the signed authorization.

VALID AUTHORIZATION: THIS AUTHORIZATION IS NOT VALID IF:

1. The expiration date has passed or the one-time event is known by the covered entity to have occurred.
2. The authorization has not been filled out completely, with respect to any applicable elements described below:
   - A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.
   - The name or other specific identification of the person authorized to make the requested use or disclosure.
   - A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
   - An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. The statement "end of the research study," "none," or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository.
   - Signature of the individual and date. If a personal representative of the individual signs the authorization, a description of such representative's authority to act for the individual must also be provided.

SACRAMENTO COUNTY

SOCIAL SERVICES AGENCY
Department of Health Services

7001A East Parkway, Suite 1000
Attn: Brenda Bongiorno
Sacramento, CA 95823
BongiornoB@SacCounty.net

Consent Agreement

I, _____, consent to having my name, photograph, image, and/or voice/quotes used for publication in newsletters, annual reports, videos, Internet/Intranet web page, audio, and presentation displays by the County of Sacramento Countywide Service and statewide programs and to be shared with media/public. I understand that my picture/image may be seen by members of the general public.

I provide my consent to use my image with the understanding that the use of my name or image in the media described above may, or will, create the implication that I am a recipient of public assistance.

I understand that I may revoke this consent agreement at any time except when action has already been taken based on this release.

NAME OF PERSON BEING PHOTOGRAPHED OR INTERVIEWED: _____
(Please Print)

SIGNATURE: _____
(PARENT/GUARDIAN/AUTHORIZED REPRESENTATIVE REQUIRED IF UNDER 18 YEARS OF AGE)

ADDRESS: _____

_____

PHONE NUMBER: _____

DATE: _____

Scan and email to
BongiornoB@sacCounty.net
(CS Photo Release 10/13)

EVENT: _____

DATE OF EVENT: _____

Accounting of Disclosures

Substance Use and Treatment Services

7001-A East Parkway, Sacramento, CA 95823

Name:	**County Record Number:**
Program/Office:	**Record Location (Address):**

Date Disclosed	**Name & Location** (Receiving Person/Entity)	**PHI/Information Disclosed** (A brief description of the information for example: psychological evaluation)	**Purpose of Disclosure** (A brief explanation of the purpose for example: in response to a Court Order)	**Disclosed By** (Name of the person who made the disclosure. **NOTE DO NOT** enter the name if it's a disclosure for child or adult abuse or domestic violence reports)

(Use additional forms as needed)

INSTRUCTIONS
Procedures on Accounting of Disclosures:

Certain disclosures are not required to be included in the accounting. All other disclosures must be included in the accounting. Disclosures that are not required to be tracked and accounted for are those that are:

- Made to carry out treatment, payment, and health care operations.
- Made to the client.
- Made to persons involved in the client's health care.
- Made pursuant to a signed authorization.
- For a facility directory.
- Made for notifications for disaster relief.
- Made prior to the original effective date of this policy, which is April 14, 2003; OR more than six years prior to the date on which the accounting is requested.
- Made as part of a limited data set in accordance with the **County of Sacramento Policy AS-100-07,** "De-identification of Client confidential information and Use of Limited Data Sets."
- For national security or intelligence purposes.
- Made to correctional institutions or law enforcement officials having lawful custody of an inmate in limited circumstances.

Examples of disclosures of Protected Health Information (PHI) that **are** required to be listed in an accounting (assuming that the disclosure is permitted by other confidentiality laws applicable to the individual's confidential information and the purpose for which it was collected or maintained) include:

- **Abuse Report:** PHI about an individual provided by County of Sacramento staff pursuant to mandatory abuse reporting laws to an entity authorized by law to receive the abuse report.

- **Audit Review:** PHI provided by County of Sacramento staff from an individual's record in relation to an audit or review of a provider or contractor.

- **Health and Safety**: PHI about an individual provided by County of Sacramento staff to protect the health or safety of a person.

- **Licensee/Provider:** PHI provided by County of Sacramento from an individual's records in relation to licensing or regulation or certification of a provider or licensee or entity involved in the care or services of the individual.

- **Legal Proceeding:** PHI about an individual that is ordered to be disclosed pursuant to a court order in a court case or other legal proceeding – include a copy of the court order with the accounting.

- **Law Enforcement Official/Court Order:** PHI about an individual provided to a law enforcement official pursuant to a court order – include a copy of the court order with the accounting.

- **Law Enforcement Official/Deceased:** PHI provided to law enforcement officials or medical examiner about a person who has died for the purpose of identifying the deceased person, determining cause of death, or as otherwise authorized by law.

- **Law Enforcement Official/Warrant:** PHI provided to a law enforcement official in relation to a fleeing felon or for whom a warrant for their arrest has been issued and the law enforcement official has made proper request for the confidential information, to the extent otherwise permitted by law.

- **Media:** PHI provided to the media (TV, newspaper, etc.) that is not within the scope of an authorization by the individual.

- **Public Health Official:** PHI about an individual provided by County of Sacramento staff (other than staff employed for public health functions) to a public health official, such as the reporting of disease, injury, or the conduct of a public health study or investigation.

- **Public Record:** PHI about an individual that is disclosed pursuant to a Public Record request without the individual's authorization.

- **Research:** PHI about an individual provided by County of Sacramento staff for purposes of research conducted without authorization, using a waiver of authorization approved by an IRB – a copy of the research protocol should be kept with the accounting, along with the other confidential information required under the HIPAA privacy rule, 45 CFR § 164.528(b)(4).