**County of Riverside**
**Authorization for Use and/or Disclosure of Patient Health Information**

**Completion of this document authorizes the use and/or disclosure of your health information. Please read the entire document (both pages) before signing.**

Patient Name:______________________________ Date of Birth:____________

Patient Address:__________________________________________________

| **I hereby authorize:** | **To release information (*specified below*) to:** |
|---|---|
| ______________________________<br>(Health Care Provider / Organization to **release** information) | ______________________________<br>(Health Care Provider / Organization to **receive** information) |
| ______________________________<br>(Address) | ______________________________<br>(Address) |
| ______________________________<br>(City, state, zip code) | ______________________________<br>(City, state, zip code) |
| ____________ ____________<br>(Phone Number) (Fax Number) | ____________ ____________<br>(Phone Number) (Fax Number) |

**I authorize the release of the following health information** *(select only one of the following)*:

- ☐ All health information about my medical history, mental or physical condition and treatment received; OR
- ☐ Only the following records or types of health information (including any dates):

______________________________________________________________

______________________________________________________________

**NOTE:** The following types of information will not be released unless specifically authorized.

**I specifically authorize the release of the following health information** (*initials required if any of the following boxes are checked*):

- ☐ Mental health treatment information Initial:________
- ☐ HIV test results Initial:________
- ☐ Alcohol / drug treatment information Initial:________

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

## County of Riverside
## Authorization for Use and/or Disclosure of Patient Health Information

**PURPOSE:** The requested use or disclosure of my health information is for the following purposes:
(1) To provide and coordinate my health care treatment and services; and
(2) To improve the quality of health care that I receive.

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**EXPIRATION:** This Authorization expires one year from the date of my signature unless a different date is specified here ______________________________ (*date*).

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**REVOCATION:** I understand that I may cancel this Authorization at any time, but I must do so by submitting my request for revocation to the Health Care Provider / Organization authorized to release the information. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

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**NOTICE OF RIGHTS AND OTHER INFORMATION:**

I understand that I do not have to sign this Authorization. My refusal will not affect my ability to obtain treatment, payment or eligibility for benefits.

I understand that I have a right to receive a copy of this Authorization.

I further understand that information disclosed by this Authorization, may be redisclosed (given to) another person or agency and may no longer be protected by federal confidentiality law (HIPAA). However, California law does not allow the person receiving my health information by this Authorization to disclose it, unless a new authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

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I have read both pages of this Authorization and agree to the use and disclosure of health information specified above.

| | |
|---|---|
| Signature of Patient | Date Signed |
| Signature of Patient's Legal Representative (if applicable) | Date Signed |
| Print Name of Patient's Legal Representative | Relationship to Patient |

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7. **Riverside County Substance Abuse Program:** When a Riverside County substance abuse program releases alcohol / drug treatment information pursuant to the Authorization Form, the information disclosed must be accompanied by the following written Legal Notice pursuant to 42 CFR 2.32:

**LEGAL NOTICE REGARDING PROHIBITION ON REDISCLOSURE**

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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 criminally investigate or prosecute any alcohol or drug abuse patient. (42 C.F.R. § 2.32)

8. **LPS Patients (Either Voluntary or Involuntary Recipients of Services):**

   LPS information or records may be disclosed in communications between qualified professional persons in the provision of services or appropriate referrals, or in the course of conservatorship proceedings. [Cal. Welf. & Inst. Code § 5328(a)]

   Consent Required. However, the consent of the LPS patient (or his/her guardian or conservator) must be obtained before LPS information or records may be disclosed by a professional person employed by a facility to a professional person not employed by the facility who does not have the medical or responsibility for the patient's care.

   Approval Required. When the LPS patient designates persons to whom information or records may be released, the approval of the physician, licensed psychologist, social worker with a master's degree in social work, or licensed marriage and family therapist, who is in charge of the patient is required.

   Note. LPS Act does not compel physician, licensed psychologist, social worker with a master's degree in social work, or licensed marriage and family therapist, nurse, attorney, or other professional person to reveal information that has been given to him/her in confidence by members of a patient's family. [Cal. Welf. & Inst. Code § 5328(a) and (b)]

**Additional Instructions:**

**County of Riverside**
**Authorization for Use and /or Disclosure of Patient Health Information**
**(Universal Consent/Release of Protected Health Information)**

1. In completing the Authorization Form, whenever possible, fill in the name of the Health Care Provider/Organization that will provide the broadest release of the patient's health information possible for both the entity that is identified to release and to receive the information. Below this name, enter the specific name and location that the health information is to be transmitted to. For example:

    a. Obtain authorization for release and receipt of the health information to "RCDMH Clinics and Programs" rather than to "Dr. X" or "X Clinic". Below this fill in, "Dr. X or X Clinic" along with the address and phone number of the specific location that the information should be transmitted to.
    b. Obtain authorization for release and receipt of the health information from "Riverside County Health Systems (outpatient primary care clinics that are operated by Riverside County) rather than from "X Family Care Center". Below this fill in, "Dr. X or X Clinic along with the address and phone number of the specific location that the information should be transmitted to.

2. There are two parts to the release:

    a. To obtain general release of health information, the patient must first either authorize release of all health information or only specific types of health information by checking the appropriate box.

    b. To obtain release of health information that is under special protection, the patient must specifically authorize the release of mental health treatment information, HIV test results and/or alcohol/drug treatment information. This requires that the appropriate boxes are checked and initialed by the patient for the release of specially protected health information to be valid.

3. For the authorization for release of all substance abuse program health information, along with the authorization form, the substance abuse clinic or program must provide the written Legal Notice to the receiving entity, which specifically prohibits redisclosure of this information. (See instructions attached to the form.)

December 30, 2012

**RIVERSIDE COUNTY CARE INTEGRATION COLLABORATIVE**
**REFERRAL / RESPONSE**

*Confidential Patient Information - See W&I Code 5328 & CFR 42*

Date of Referral:

| | | | | |
|---|---|---|---|---|
| **REFERRAL FROM:** | ☐ AB109 (OP/FSP) | ☐ Mental Health | ☐ Substance Abuse | ☐ Primary Care |
| **Program Location:** | ☐ Blaine | ☐ Atlanta (circle) D1 D2 D3 | | ☐ Rubidoux |
| ***REFERRAL TO:*** | | ☐ *Mental Health* | ☐ *Substance Abuse* | ☐ *Primary Care* |
| ***Program Location:*** | ☐ *Blaine* | ☐ *Atlanta (circle) D1 D2 D3* | | ☐ *Rubidoux* |

**Referring Provider (1) Name:** ________________ ☐ **M.D.** ☐ **N.P.** ☐ **MH Staff**

**Other Treating Provider (2) Name:** ________________ ☐ **M.D.** ☐ **N.P.** ☐ **MH Staff**

**Provider 1** Phone: Fax: E-mail:

**Provider 2** Phone: Fax: E-mail:

| **Patient/Client Name:** | | **D.O.B.:** | |
|---|---|---|---|
| **MR #** | | **M/C or RCHC ID#** | |

**Reason for the Referral** (Explain reason including and prior substance abuse evaluation and treatment provided):

Medical or DSM Diagnosis(es)

Important Laboratory and/or Diagnostic Test Information:

Medications Prescribed and Treatment Plan Summary:

Other Area(s) of Inquiry/Comments.

| **RESPONSE TO REFERRAL** | Date of Evaluation/Assessment: | |
|---|---|---|
| **Evaluating/Reporting Provider Name:** | | |
| **Provider's:** Phone: | Fax: | E-mail: |

Medical or DSM Diagnosis(es)

Important Laboratory and/or Diagnostic Test Information:

Medications Prescribed and Treatment Plan Summary:

Other Recommendations/Comments.

Disposition:
☐ Continue treatment with receiving program
☐ No further treatment necessary/ Follow-up with referring program as needed.

Reporting Provider Signature ________________ Date ________________

# Blaine Integrated Health Services
# Referral Protocols

**Mental Health Providers:**

Consumers without access to primary health care and/or unengaged in receiving routine services from their PCP should be considered for referral to Blaine Integrated Health team. The goal for unengaged consumers would be education, linkage and support to re-engage in regular health care with their PCP.

Prior to initiating the referral, the referring RCDMH program must:

- ☐ Fully register the consumer in ELMR (**Registration, CSI and PFI**).
- ☐ Screen consumers at Intake and annual reassessment using the **Medical Data Sheet**.
- ☐ Have a complete and current **Assessment** that includes documented medical necessity for: **#9 Physical Health Life Domain**.
- ☐ Have a completed Client Care Plan **Goal for #9 Physical Health Care**
- ☐ If the consumer is uninsured, have a documented plan for applying/obtaining RCHC.

**When above actions have been completed:**

- ☐ Complete the Riverside County **Care Integration Collaborative (CIC) Referral/Response Form**
  *Make sure that you indicate which program and location is initiating the referral (important for primary care staff to know how to contact you, billing and response communication).*

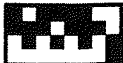
- ☐ Deliver, Scan and e-mail, or FAX the Health Screening Form and Referral/Response Form to Blaine Integrated Health Triage nurse.

**Blaine Integrated Health Triage Nurse:**

- ☐ Confirm that referral is registered in ELMR and that PFI, Assessment and CCP are current.
- ☐ Review Health Screening Form and CIC Referral Response Form, consulting with NP as appropriate.
- ☐ Document in appropriate ELMR program RU that referral was received and plan (so that MH team providers have easy access to action). Coordination services are reimbursable.
- ☐ Notify Business Office OA III to verify RCHC/payor status and schedule for appointment. *(Note for unengaged consumers that may have insurance coverage, insurance alone shall not be a barrier for a one time consultation with NP).*
- ☐ Upon disposition of primary care appointment
  a. Complete referral/response form and have scanned into ELMR record
  b. Document outcome in ELMR Progress Note
  c. e-mail referring provider to check record for disposition

**Integrated Health OA III**

- ☐ Determines any existing M/C or RCHC eligibility status and informs the Integrated Health nurse and/or NP as needed
- ☐ Schedules client to see NP provider in BCA
- ☐ Scans Health Screening Survey and CIC Referral/Response Form into consumer's ELMR record
- ☐ Places original CIC Referral/Response Form into a central binder in alpha order by FY



61013

# Blaine Clinic Client Medical Data Sheet

*Confidential Client Information see CA, W&I code, section 5328*

**Client's First Name**

**Today's Date** ___ / ___ / ___

**Client's Last Name**

**Funding Source (mark all that apply)**

- O Medi-Cal
- O Molina (Medi-Cal)
- O IEHP (Medi-Cal)
- O Medicare
- O Medi-Medi
- O Private Insurance
- O Unfunded/No Insurance
- O Other(Please specify)

**Client's Date of Birth** ___ / ___ / ___

**Gender** O Male O Female

**Client ID Number**

**Staff Completing**

**Staff Type**

## Medical Conditions Reported by Client (mark all that apply)

- O None
- O Heart Problems / Heart Attacks
- O Arterial or Vascular Diseases
- O Stroke
- O High Blood Pressure
- O High Cholesterol
- O Obesity / Morbid Obesity
- O Asthma
- O COPD / Lung Disease / TB / Breathing Problems

**Males Only:**

- O Prostate Problems
- O Impotence

**Females Only:**

- O Currently Pregnant or Nursing
- O Excessive Menstrual Bleeding
- O Pelvic Pain/Cramping/Vaginal Discharge
- O Breast Lump/Mass/Pain

When was the last mammogram exam?

O In the last 2 years O Over 2 years O Don't Remember O Never

When was the last pelvic exam?

O In the last 2 years O Over 2 years O Don't Remember O Never

- O Diarrhea/Blood in Stools
- O Constipation/Pain on Bowel Movements
- O Liver Problems/Hepatitis B or C
- O Arthritis/Joint Pain
- O Chronic Back Pain
- O Thyroid/Endocrine (Hormonal) Problems
- O Kidney Problems
- O Diabetes Type I O Type II O

Insulin Dependent: Yes O No O

- O Cancer
- O Urinary Problems, Infections or Bleeding
- O Epilepsy / Convulsions / Seizures
- O HIV/AIDS
- O Abdominal Pain, Cramping
- O Other

**Does the medical condition reported require treatment?** O **Yes** O **No**

**If yes, what treatment?**

O Medications prescribed O Other Treatment (please specify)

61013

**Client ID Number (Same as previous page)**

**Today's Date (Sane as previous page)**

/ /

**List any additional medications prescribed for the conditions you marked on the previous page.**

**Indicate the number of emergency room interventions (e.g., emergency room visit, crisis stabilization unit) the client had DURING THE PAST 12 MONTHS that were:**

Physical Health Related

Mental Health/Substance Abuse Related

**Indicate the number of hospitializations DURING THE PAST 12 MONTHS that were:**

Physical Health Related

Mental Health/Substance Abuse Related

**Does the client have a primary care physician (PCP)?** O Yes O No

**Last physical examination:** O In last 2 years O Over 2 years O Don't remember O Never

**Doctor's Name**

**Date of Last PCP Visit**

/ /

**Primary Care Clinic Phone Number**

**Primary Care Clinic Name**

**Primary Care Clinic Address**

Clinician Signature

**Date of Signature**

/ /

# HEALTH SCREEN

Please circle or check your response:

A. Over the past 2 weeks, how often have you been bothered by any of the following problems?

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed or hopeless | 0 | 1 | 2 | 3 |

| | YES | NO |
|---|---|---|
| 1. Have you ever felt that you ought to cut down on your drinking or drug* use? | ☐ | ☐ |
| 2. Have people annoyed you by criticizing your drinking or drug* use? | ☐ | ☐ |
| 3. Have you ever felt bad or guilty about your drinking or drug* use? | ☐ | ☐ |
| 4. Have you ever had a drink or used drugs* first thing in the morning to steady your nerves or to get rid of a hangover? | ☐ | ☐ |

*Drugs refer to illegal drugs and prescription drugs.

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| | | |
|---|---|---|
| In the last month have you had thoughts that you would be better off dead or hurting yourself? | ☐ | ☐ |

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Office Staff:
Score: ___________

Signature: ___________________________________ Date: _________________

| | RIVERSIDE COUNTY HEALTH SYSTEM<br>DIVISION OF AMBULATORY CARE |
|---|---|