UNIVERSAL RELEASE FORM

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

CLIENT:

Last Name, First Name, Middle Initial	*Date of Birth (Mo/Day/Year)*	*Medi-Cal CIN # or My Health LA ID #*

Street Address	*City, State, and Zip Code*

I permit the entities listed below to release, disclose, use, receive, and/or exchange my Protected Health Information for the purpose of coordinating my care and treatment.

I. IDENTITY OF ENTITIES WHO MAY SHARE INFORMATION

I authorize the following entities and their contracted healthcare providers participating in my treatment to share my health information with each other:

- My health plan (***please check one as appropriate***):

  □ Anthem Blue Cross/Care More □ Health Net □ Care 1st

  □ LA Care □ Molina Health Care □ Kaiser Permanente
- LA County Department of Health Services (DHS)
- LA County Department of Mental Health (DMH)
- LA County Department of Public Health, Substance Abuse Prevention and Control (DPH-SAPC)
- LA County Department of Public Health, Division of HIV and STD Programs (DPH-DHSP)

II. DESCRIPTION OF HEALTH INFORMATION

I permit the entities listed in Section I to share any information in my medical file. This may include information related to my care or treatment; medical and pharmacy records; information related to my application for, enrollment in, and eligibility for health care services; information about the health care benefits I receive and claims that seek payment for these benefits; and other information necessary to coordinate my care and treatment.

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By signing this Authorization, I specifically permit the entities listed in Section I to share my health information that relates to the following types of services I receive (if any)**:**

- Physical health
- Mental health
- Drug or alcohol abuse diagnosis, treatment, prognosis, or referral
- HIV/AIDS-related information, including AIDS-related complex (ARC)
- Genetic testing

III. EXPIRATION OF AUTHORIZATION:

This Authorization will automatically expire one year after the date listed in the Client Signature section on page 3.

IV. OTHER IMPORTANT INFORMATION:

By signing this Authorization, I understand that:

- I do not need to sign this Authorization in order to receive treatment or Cal MediConnect/ Medi-Cal benefits, enroll in Cal MediConnect/Medi-Cal, or for Cal MediConnect/Medi-Cal to pay for my health care.

- I have a right to receive a copy of this Authorization. A copy of this Authorization is as valid as the original.

- Entities that receive my health information under this Authorization may not be required to follow the same privacy rules as the entity that shared the information and could re-disclose my health information.

- However, if information related to drug or alcohol abuse or HIV/AIDS treatment is shared, that information cannot be re-disclosed except with another Authorization.

- I have the right to revoke this Authorization at any time in writing unless the entity disclosing my health information already shared my information before receiving my revocation. I may use the Revocation of Authorization at the bottom of this form to terminate this Authorization. Mail or deliver the revocation to your Health Plan.

Once my Revocation of Authorization is received, my health plan will cancel the Authorization.

I have read and understand the content of this Authorization. I am signing the Authorization voluntarily, and understand that I have the right to refuse to sign the form. My signature authorizes the disclosure of the health information as described in this Authorization.

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Signature of Client or Client's Legal Representative:

____ ________/________/________
Month Day Year

If signed by Client's Legal Representative, state relationship and authority to do so:

____

Witness: Signature of Doctor, Providers, or Agency/Clinic Representative:

____ ________/________/________
Month Day Year

____
Street address *City, State, Zip Code*

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Revocation of Authorization

I wish to revoke my authorization. (Please send to your Health Plan)

Signature of Client or Client's Legal Representative:

____ ________/________/________

Month *Day* *Year*

If signed by Client's Legal Representative, state relationship and authority to do so:

____

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ADDENDUM

Below is an alphabetical list of substance use disorder (SUD) providers within the SAPC network who are authorized to share health information, as referenced in the above Authorization form. Please circle the relevant SUD providers and enter the other health providers below who will be exchanging health information with this Universal Release Form.

Other Providers (if applicable):

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Substance Use Disorder Providers:

Please visit the *SUD Provider Locator* section at http://publichealth.lacounty.gov/sapc/ for the most current list of providers.

- ADDICTION RESEARCH AND TREATMENT, INC.
- AEGIS TREATMENT CENTERS, LLC
- ALCOHOLISM CENTER FOR WOMEN, INC.
- ALCOHOLISM COUNCIL OF ANTELOPE VALLEY/NCA
- ALTAMED HEALTH SERVICES CORPORATION
- AMERICAN HEALTH SERVICES LLC
- AMERICAN INDIAN CHANGING SPIRITS
- ASIAN AMERICAN DRUG ABUSE PROGRAM, INC.
- AVALON-CARVER COMMUNITY CENTER
- BAART BEHAVIORAL HEALTH SERVICES, INC.
- BEACON HOUSE ASSOCIATION OF SAN PEDRO (THE)
- BEHAVIORAL HEALTH SERVICES, INC.
- CALIFORNIA HISPANIC COMMISSION ON ALCOHOL AND DRUG ABUSE, INC.
- CAMBODIAN ASSOCIATION OF AMERICA
- CANON HUMAN SERVICES, INC.
- CASA DE LAS AMIGAS
- CENTER FOR INTEGRATED FAMILY AND HEALTH SERVICES
- CHABAD OF CALIFORNIA, INC.
- CHILD AND FAMILY CENTER
- CHILDREN'S HOSPITAL LOS ANGELES
- CLARE FOUNDATION, INC.
- CLINICA MONSENOR OSCAR A. ROMERO
- CRI-HELP, INC.
- DIDI HIRSCH PSYCHIATRIC SERVICE
- DIVINE HEALTHCARE SERVICES, INC.
- EGGLESTON YOUTH CENTERS, INC., D. B. A. EGGLESTON SUBSTANCE ABUSE AND EDUCATION PROGRAM
- EL PROYECTO DEL BARRIO
- ELDORADO COMMUNITY SERVICE CENTER
- ETTIE LEE HOMES, INCORPORATED
- EXODUS RECOVERY INC
- FAMILIES FOR CHILDREN, INC.
- GRANDVIEW FOUNDATION, INC.
- HACC, INC., D.B.A. HARBOR AREA SUBSTANCE ABUSE TREATMENT CENTER
- HANNAH'S FIRST STEP TREATMENT CENTER
- HELPING KIDS TO RECOVER, INC.
- HELPLINE YOUTH COUNSELING, INC.
- HIS SHELTERING ARMS, INC.
- HOLY ADDICTION CARE CENTER, INC
- HOMELESS HEALTH CARE LOS ANGELES, INC.
- HOUSE OF HOPE FOUNDATION, INC.

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- I-ADARP, INC.
- JWCH INSTITUTE, INC.
- LITTLE HOUSE
- LIVE AGAIN RECOVERY HOME, INC.
- LOS ANGELES BIOMEDICAL RESEARCH INSTITUTE AT HARBOR-UCLA MEDICAL CENTER
- LOS ANGELES CENTERS FOR ALCOHOL AND DRUG ABUSE
- MATRIX INSTITUTE ON ADDICTIONS
- MEDI-CURE HEALTH SERVICES, INC.
- MELA COUNSELING SERVICES CENTER, INC.
- MOTIVATIONAL RECOVERY SERVICES, INC.
- NARCOTIC ADDICTION TREATMENT AGENCY, INC.
- NARCOTIC PREVENTION ASSOCIATION, INC.
- NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE - LONG BEACH AREA
- NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE OF EAST SAN GABRIEL AND POMONA VALLEYS, INC.
- NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE OF THE SAN FERNANDO VALLEY
- NEW HOPE DRUG & ALCOHOL TREATMENT PROGRAM, INC.
- PACIFIC CLINICS
- PACIFIC LODGE YOUTH SERVICES, INC.
- PALM HOUSE, INC.
- PEOPLE COORDINATED SERVICES OF SOUTHERN CALIFORNIA
- PHOENIX HOUSES OF LOS ANGELES, INC.
- PRINCIPLES, INC.
- PROTOTYPES, CENTERS FOR INNOVATION IN HEALTH, MENTAL HEALTH, AND SOCIAL SERVICES
- RENAISSANCE SOUTH LA, INC
- SAFE REFUGE (original name: SUBSTANCE ABUSE FOUNDATION OF LONG BEACH, INC.)
- SAN FERNANDO VALLEY COMMUNITY MENTAL HEALTH CENTER, INC.
- SANTA ANITA FAMILY SERVICES
- SHIELDS FOR FAMILIES, INC.
- SOCIAL MODEL RECOVERY SYSTEMS, INC.
- SOUTH BAY HUMAN SERVICES COALITION
- SOUTHERN CALIFORNIA ALCOHOL AND DRUG PROGRAMS, INC.
- SOUTHWEST CARE, INC.
- SPECIAL SERVICE FOR GROUPS, INC.
- SPIRITT FAMILY SERVICES
- SUNRISE COMMUNITY COUNSELING CENTER
- TARZANA TREATMENT CENTERS, INC.
- TAVARUA HEALTH SERVICES
- TAVARUA MEDICAL REHABILITATION SERVICES D.B.A. ASUZA MEDICAL AND MENTAL HEALTH SERVICES
- THE NEW YOU CENTER, INC.
- THE PAJO CORPORATION
- THE SALVATION ARMY, A CALIFORNIA CORPORATION
- TRANSCULTURAL HEALTH DEVELOPMENT, INC.
- TWIN TOWN CORPORATION
- VALLEY WOMEN'S CENTER, INC.
- VAN NESS RECOVERY HOUSE
- VOLUNTEERS OF AMERICA OF LOS ANGELES
- WATTS HEALTHCARE CORPORATION
- WEST COUNTY MEDICAL CLINIC
- WEST COUNTY MEDICAL CORPORATION
- WESTERN PACIFIC MED-CORP
- WILSHIRE TREATMENT CENTER, INCORPORATED
- YOU CAN HEALTH SERVICES

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