

## **Instructions for Completing the SAPC Consent for Payment and Healthcare Operations Form**

The purpose of this consent form is to authorize payment for all services rendered for the treatment of substance use disorder (SUD) and to permit the release of your **42 CFR Part 2** protected SUD health information from your current, past, and future treating providers within the Substance Abuse Prevention and Control's (SAPC) Provider Network to SAPC, in its role as the Medi-Cal Specialty SUD Plan for SUD services, for purposes of payment for services received and other health care operations. Under HIPAA, "Health care operations" includes a range of activities such as conducting/arranging for auditing services, including fraud and abuse detection, compliance programs, business management and general administrative activities. This consent also authorizes submission and payment to the California Department of Health Care Services (DHCS), Managed Care Plans (MCP), and other third-party payors and the release of all information necessary to submit and process claims.

Please be aware your authorization is voluntary and you may refuse to sign this consent form. However, if you do not sign this consent, you are accepting responsibility for all payments, including any amounts that would otherwise be billed to or reimbursed by SAPC, in its role as the Medi-Cal specialty SUD plan as well as any applicable third-party payers, and you will be responsible for all associated out-of-pocket costs. Please review these instructions before continuing.

### Read Each Section Carefully

This form includes several sections describing:

- **What information** may be shared
- **Who** may send and receive the information
- **Why** the information is being shared
- **How long** the authorization to release information lasts
- **Your rights** to revoke the authorization to release information
- **Your right** to refuse to sign and its consequences

Please **read and review each section** thoroughly before signing.

### Who May Share and Receive Your Information

By signing this form, you agree to authorize the sharing of 42 CFR Part 2 protected SUD health information from current, past, and future treating providers within the SAPC Provider Network to SAPC in its role as a Medi-Cal specialty SUD plan for purposes of payment and other health care operations. You will also authorize the release of information from your medical record to SAPC or other third-party payers, including all information necessary to submit and process claims such as your name, date of birth, address, medical diagnosis, and services provided to you.

Please refer to Section II "Entities Authorized to Share Health Information" and Section III "Other Important Information".

### Review Your Rights Under HIPAA and 42 CFR Part 2

This form states your rights under Federal and State laws. You have the right to:

- **Refuse to sign** this authorization
- **Revoke** your authorization at any time in writing or in-person
- **Receive a copy** of the completed form
- **Expect confidentiality protections**, including redisclosure limits

Please refer to Section III "Other Important Information" and Section V "Notice to Accompany Disclosures" for more information related to your rights under HIPAA and 42 CFR Part 2.

### Expiration of Authorization

This authorization does not expire and will remain in effect unless you choose to revoke it.

Please refer to Section III "Other Important Information" and Section VI "Revocation of Consent" for more information on your authorization rights.

## Revoking Your Authorization

You may revoke your authorization at any time by notifying your treating provider or program in writing or in-person. Revocation does **not** undo information already shared before the revocation was received. Services rendered prior to the revocation will still be considered authorized for the purposes of payment and healthcare operations.

Please refer to Section III “Other Important Information” and Section VI “Revocation of Consent” for more information on how to revoke your authorization.

## Electronic Exchange and Security

All disclosures—including those made electronically—must comply with:

- **HIPAA** requirements
- **42 CFR Part 2**
- Other applicable Federal and State **confidentiality laws**

## Sign and Date the Form

Your signature confirms that:

- You **understand** the information on the form
- You **authorize the release of the information** described
- You **understand your rights** under HIPAA and 42 CFR Part 2

If you are signing as a **legal representative**, you must indicate your authority to do so. Examples of legal authority include Parent, Legal Guardian, Conservator, Executor of Estate, Power of Attorney, and/or Next of Kin. You will be required to provide additional documentation to corroborate your authority to consent on the client’s behalf.

If you are signing as a witness for signature by mark, please fill out the appropriate section with your information.

## Return the Completed Form

Return the signed form to the provider, program, or agency responsible for processing your request. You may request a copy for your records.

**SUBSTANCE ABUSE PREVENTION AND CONTROL (SAPC)**

**CONSENT FOR PAYMENT AND HEALTHCARE OPERATIONS**

**Purpose of Consent and Disclosure:** The purpose of this consent is to authorize payment for all services rendered for the treatment of Substance Use Disorder (SUD) and to permit the release of my 42 CFR Part 2 protected SUD health information from my current, past, and future treating providers within the SAPC Provider Network to SAPC, in its role as the Medi-Cal Specialty SUD Plan for SUD services, for purposes of payment and other health care operations. This consent also authorizes submission and payment to the California Department of Health Care Services (DHCS), Managed Care Plans (MCP), and other third-party payors and the release of all information necessary to submit and process claims.

**I. CLIENT INFORMATION**

Name (Last, First, and Middle):	Date of Birth:	Medi-Cal #:
Email Address: <small>By providing your email address, you are authorizing SAPC and SAPC's Provider Network to contact you by email.</small>	Phone Number:	Last 4 Digits of SSN:
Address:		Sage ID #:

**II. ENTITIES AUTHORIZED TO SHARE HEALTH INFORMATION**

I consent to the release of my 42 CFR Part 2 protected SUD health information from my current, past, and future treating providers within the SAPC Provider Network to SAPC in its role as a Medi-Cal specialty SUD plan for purposes of payment and other health care operations. I authorize the release of information from my medical record to SAPC or other third-party payers, including all information necessary to submit and process claims such as my name, date of birth, address, medical diagnosis, and services provided to me.

**III. OTHER IMPORTANT INFORMATION**

By signing this Consent form, I understand that:

- **Expiration of Consent** - This Authorization will remain in effect until otherwise revoked.
- My alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise permitted by the regulations.
- **Right not to sign:** This Consent is for payment of my healthcare and other healthcare operations. I recognize I have the right not to sign this consent. If I do not sign this consent, I am accepting responsibility for all payments, including any amounts that would otherwise be billed to or reimbursed by SAPC, in its role as the Medi-Cal specialty SUD plan, as well as any applicable third-party payers, and I will be responsible for all associated out-of-pocket costs.
- I acknowledge that this authorization is necessary to determine eligibility for treatments or benefits or to pay for treatments I receive, but SAPC cannot condition my treatment on providing this authorization.
- I have a right to receive a copy of this Consent form. A copy of this Consent form is as valid as the original.
- **Redislosure Information** - Information related to alcohol or drug treatment disclosed to a covered entity or business associate may be redislosed in accordance with the permissions contained in the HIPAA regulations.
- **Limitations for Redislosure** – Disclosed information cannot be redislosed for civil, criminal, administrative, and legislative proceedings against the client without an additional Consent form that is solely for this purpose consistent with the 42 C.F.R. Part 2.

- I have right to right to revoke this Consent at any time in writing or in person with my treating substance use provider, except to the extent that my provider or other lawful holder has already acted in reliance on it. I may use the Revocation of Consent section on this Consent form to terminate this Consent form in writing. Once my Revocation of Consent is received, my provider or SAPC will revoke the Consent for future release of information. I understand disclosures made prior to revoking this consent form cannot be retrieved and the entities to whom the disclosures were made are not required to return or dispose of the disclosures.

#### IV. SIGNATURE OF CLIENT OR LEGAL REPRESENTATIVE

By signing below, I acknowledge I have read the Consent form and understand my signature authorizes the disclosure of my health information as described on this form. I understand that signing this form is voluntary and I have the right to refuse to sign.

**Name and Signature of Client or Client’s Legal Representative:**

If the client cannot write, they may make a mark on the signature line. Signature by mark requires two witnesses. A witness must write the client’s name on the line designated for the client’s name and write their own name and sign on one of the designated witness spaces below. A second witness must write their name and sign on the other witness space to acknowledge the client’s signature by mark.

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Print Name (First Middle and Last)                      Signature                      Month                      Day                      Year

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

\_\_\_\_\_

If the client cannot write and has provided a mark as their signature above, two witnesses are required to complete the witness section by writing their names and signing below.

1. \_\_\_\_\_                      2. \_\_\_\_\_  
 Print Witness Name (First Middle and Last)                      Print Witness Name (First Middle and Last)

\_\_\_\_\_                      \_\_\_\_\_  
 Signature                      Signature

#### V. NOTICE TO ACCOMPANY DISCLOSURES

This record which has been disclosed to you is protected by Federal confidentiality rules ([42 CFR part 2](#)). These rules prohibit you from using or disclosing this record, or testimony that describes the information contained in this record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against the client, unless authorized by the consent of the client, except as provided at [42 CFR 2.12\(c\)\(5\)](#) or as authorized by a court in accordance with [42 CFR 2.64](#) or [2.65](#). In addition, the Federal rules prohibit you from making any other use or disclosure of this record unless at least one of the following applies:

- (i) Further use or disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or as otherwise permitted by [42 CFR part 2](#).
- (ii) You are a covered entity or business associate and have received the record for treatment, payment, or health care operations, or
- (iii) You have received the record from a covered entity or business associate as permitted by [45 CFR part 164, subparts A and E](#).

A general authorization for the release of medical or other information is NOT sufficient to meet the required elements of written consent to further use or redisclose the record (see [42 CFR 2.31](#)).

## VI. REVOCATION OF CONSENT

I have the right to revoke this Consent form at any time by completing this section and providing my Revocation of Consent by mail or in person to my treating substance use provider, except to the extent that my provider or other lawful holder has already acted in reliance on it.

**Treating Substance Use Provider Agency's Mailing Address:**

Organization Name: \_\_\_\_\_

Street Address (Line 1): \_\_\_\_\_

Street Address (Line 2: Apt/Suite/Unit): \_\_\_\_\_

City, State, and Postal Code: \_\_\_\_\_

Once my Revocation of Consent is received, my provider will revoke the Consent form for future release of information. Disclosures made prior to receiving the revocation cannot be retrieved.

By signing below, I revoke my Consent for future release of information for payment and health care operations. I understand that any disclosures made prior to the receipt of this revocation cannot be undone or retrieved.

**Name and Signature of Client or Client's Legal Representative:**

If the client cannot write, they may make a mark on the signature line. Signature by mark requires two witnesses. A witness must write the client's name on the line designated for the client's name and write their own name and sign on one of the designated witness spaces below. A second witness must write their name and sign on the other witness space to acknowledge the client's signature by mark.

\_\_\_\_\_  
Print Name (First Middle and Last)                      Signature                      \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month                      Day                      Year

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

\_\_\_\_\_

If the client cannot write and has provided a mark as their signature above, two witnesses are required to complete the witness section by writing their names and signing below.

1. \_\_\_\_\_                      2. \_\_\_\_\_  
Print Witness Name (First Middle and Last)                      Print Witness Name (First Middle and Last)

\_\_\_\_\_  
Signature                      \_\_\_\_\_  
Signature

Clients who submitted a Release of Information Consent form directly to SAPC may return the completed Revocation of Consent form through secure email or by mail to the address listed below. A copy of their official government-issued identification must be included to verify the legitimacy of the request.

SAPC's Mailing Address  
Substance Abuse Prevention and Control  
1000 South Fremont Ave.  
Bldg. A-9 East 3<sup>rd</sup> Floor Box 34  
Alhambra, CA 91803

Email Address:  
SAPC-HIM@ph.lacounty.gov

Please note: Revocation requests submitted to SAPC from clients who did not complete Release of Information Consent form directly with SAPC, or requests submitted without a copy of a valid government-issued ID, will not be processed.



## How to fill out the SAPC Consent for Payment and Healthcare Operations Form

### Purpose of Consent and Disclosure (Top of Form)

This section explains that you are authorizing:

- SAPC to receive your SUD information for **payment and healthcare operations**, and
- SAPC, DHCS, MCPs, and other payors to receive the information needed to **submit and process claims**.
- **This form is required** if you would like for SAPC to bill Medi-Cal or other payors for your SUD services.

### Section I — Client Information

Fill in your personal information so SAPC and your providers can correctly identify your record.

1. **Name:** Write your full legal name (Last, First, Middle).
2. **Date of Birth:** Use MM/DD/YYYY.
3. **Medi-Cal #:** Enter your Medi-Cal number, if you have one.
4. **Email Address:** Enter an email you check regularly.
5. **Phone Number:** Best telephone number to reach you.
6. **Last 4 Digits of SSN:** Enter only the last four digits of your Social Security Number. If you do not have an SSN or know what your SSN is, then please leave blank.
7. **Address:** Your current mailing address.
8. **Sage ID #:** Provide your Sage EHR medical record number, if known. If unknown, leave blank or ask your provider.

### Section II — Entities Authorized to Share Health Information

No writing is required in this section. This section explains that you are authorizing your **current, past, and future SAPC treating providers** to release your SUD information to **SAPC and to third-party payors** (DHCS, MCPs, insurance plans) for **payment and healthcare operations**

### Section III — Other Important Information

You do not need to write anything in this section. Read each subsection carefully.

- **Expiration:** Your Consent stays active until you revoke it.
- **Protections:** Your records are protected by federal laws under **42 CFR Part 2** and **HIPAA**.
- **Right Not to Sign:** You can refuse to sign, if you do so you will be responsible for **costs associated with your care**.
- **Right to a Copy:** You may request a copy of the signed consent.
- **Redisclosure:** Some of your information may be redisclosed under HIPAA under limited circumstances.
- **Legal Protections:** Your information cannot be used in legal proceedings without a separate consent.
- **Right to Revoke:** You may revoke this consent at any time. Information already shared cannot be taken back.

### Section IV — Signature of the Client or Legal Representative

This is where you formally authorize the release.

1. **Print Name:** Your full legal name.
2. **Signature:** Sign your name.
  - a. If you cannot write, you may sign with a mark.
  - b. If signing by mark, **two witnesses** must complete the witness section.
3. **Date:** Enter the date of signing.
4. **If signed by a Legal Representative:**
  - a. State the relationship (e.g., parent, guardian, etc.).
  - b. State the authority (e.g., court order, conservatorship, etc.).
5. **Witness Section (only if client signs by mark)**

Two witnesses must:

- Print their names legibly
- Sign their names

If a **legal representative** signs on behalf of a client, they must state their relationship and legal authority to do so. If the client **signs with a mark**, two witnesses must print and sign their names.

## Section V — Notice to Accompany Disclosures

This is the required 42 CFR Part 2 confidentiality notice that will accompany your information. No writing is required in this section. The Notice to Accompany Disclosures is a confidentiality notice that will accompany records released as authorized by the signing of this form. The confidentiality notice notifies the receiver of the records that the records being received are protected under State and Federal confidentiality laws and cannot be shared with other entities not authorized by this consent form.

## Section VI — Revocation of Consent

Complete this section **only when you want to revoke your consent (i.e. in the future)**.

### Step 1 — Provider Information

Fill in the treating provider's:

- **Organization Name**
- **Full mailing address**

### Step 2 — Revocation Signature

1. **Print your name**
2. **Sign your name (or make a mark).**
3. **Date the revocation (MM/DD/YYYY)**
4. If a **legal representative** signs, **state relationship and authority** to do so
5. If submitting directly to SAPC, please **include a copy of your government-issued ID** in order to verify your identity

### Step 3 — Witnesses (if signing by mark)

Two witnesses must print and sign their names.

### Step 4 — Submit the revocation

If you originally submitted the consent directly to SAPC, you may send the revocation:

- **By secure email** to SAPC-HIM@ph.lacounty.gov (must include a copy of your government-issued ID)
- **By mail** to the SAPC address listed on the form

Please send revocations to your provider, agency, or to SAPC using the instructions on the form.

## Additional Definitions

### Authorization / Consent

A written, signed document that meets all 42 CFR Part 2 requirements, including:

- Purpose of disclosure
- Who may disclose
- Who may receive
- What information may be shared
- Expiration
- Signature and date

Each SAPC ROI form is designed to meet these requirements for its specific purpose

### Care Coordination

Communication and collaboration between providers to support a client's treatment, referrals, case management, and continuity of care.

## Client

The individual receiving substance use disorder (SUD) services. The client is the person whose protected health information (PHI) may be shared when they sign an ROI.

## Entity

Any organization, agency, provider, court, attorney, or individual authorized to receive or disclose SUD information. Examples: SAPC providers, DHCS, Managed Care Plans, courts, probation, primary care providers.

## Legal Proceedings

Any criminal, civil, administrative, or legislative process where SUD information may be requested or used against the client. Examples: court hearings, probation, child welfare cases, social security benefit determination hearings.

## Legal Representative

A person legally authorized to make decisions on behalf of the client. Examples:

- Court-appointed conservator
- Legal guardian
- Parent of a minor They may sign the ROI only when they have documented legal authority.

## Minimum Necessary Standard

Under HIPAA definitions, the least amount of information needed to fulfill the purpose of the consent may be shared.

## Payment & Healthcare Operations

Administrative activities needed to bill, pay, or manage SUD services, including:

- Medi-Cal billing
- Eligibility checks
- Utilization review
- Quality improvement
- Audits and compliance reviews

## Redisclosure

Any sharing of SUD information after the initial disclosure. Under 42 CFR Part 2, redisclosure is **permitted**, except for legal proceedings.

## Revocation of Consent

The client has a right to withdraw their consent at any time. Withdrawing consent cannot undo past disclosures already made when the consent was in place. Revocation must be in writing or completed using the revocation section of the ROI form.

## Third-Party Payor

Any entity responsible for paying or reimbursing SUD services other than the client themselves. Examples: Medi-Cal, DHCS, Managed Care Plans, private insurance.

## Treating Provider / SAPC Provider Network

Any SUD treatment program contracted with LA County SAPC, including outpatient, residential, OTP, withdrawal management, and recovery support programs.

## Witness

A person who observes the client sign the ROI **by mark** (when the client cannot write a signature). Two (2) witnesses must print and sign their names in order for mark to be considered valid.