California HealthCare Foundation

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Fine Print:
Rules for Exchanging Behavioral Health Information in California

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About the Foundation

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Introduction

Almost a decade after the Institute of Medicine issued a clarion call for better care coordination and information sharing among physical, mental health, and substance abuse treatment providers, the changes urged in the report have yet to be fully realized.[1] Health care providers report difficulties sharing critical health information about patients, citing a number of challenges:

- Up-front and ongoing maintenance costs associated with adoption of health information technology.
- Federal and state law confidentiality requirements that make sharing of mental health and substance abuse information more challenging.
- Disparate electronic health record (EHR) systems that do not easily "talk" with one another.
- An entrenched culture of separate systems unaccustomed to working together as one care team.[2]

This report describes the legal framework for sharing behavioral health information in California, under both federal and state law. (Figure 1 on page 4 illustrates how those laws work in practice.) It also profiles initiatives in San Diego and Alameda Counties and by Inland Empire Health Plan (a Medi-Cal managed care plan operating in San Bernardino and Riverside Counties) that enable some sharing of behavioral health data for care coordination, and explores the initiatives' replicability in other settings.

Legal analysis and the experiences of participants in these initiatives point to four key issues for providers and policymakers to address in order to improve the integration of behavioral and physical health care:

1. Current state policies enable the sharing of mental health data, and such sharing is occurring today, but clarification from regulators could help eliminate perceived barriers that serve as obstacles to sharing in many settings throughout the state.
2. Sharing substance abuse treatment data is a bigger challenge, likely requiring greater regulatory flexibility, at both the state and federal level, in how patient consent to share this data is operationalized.
3. Behavioral and physical health care teams function in silos for reasons that go beyond legal impediments to data sharing, so bringing them together will require culture change.
4. Technological barriers to interoperability pose a particular challenge for the sharing of electronic behavioral health data and contribute to the segmentation of both information and care processes. Solving the interoperability issues will not by itself change culture, but it could enable data to be shared in ways that fit with behavioral and physical health provider workflows, laying the foundation for greater coordination.

Legal Framework for Sharing Behavioral Health Information

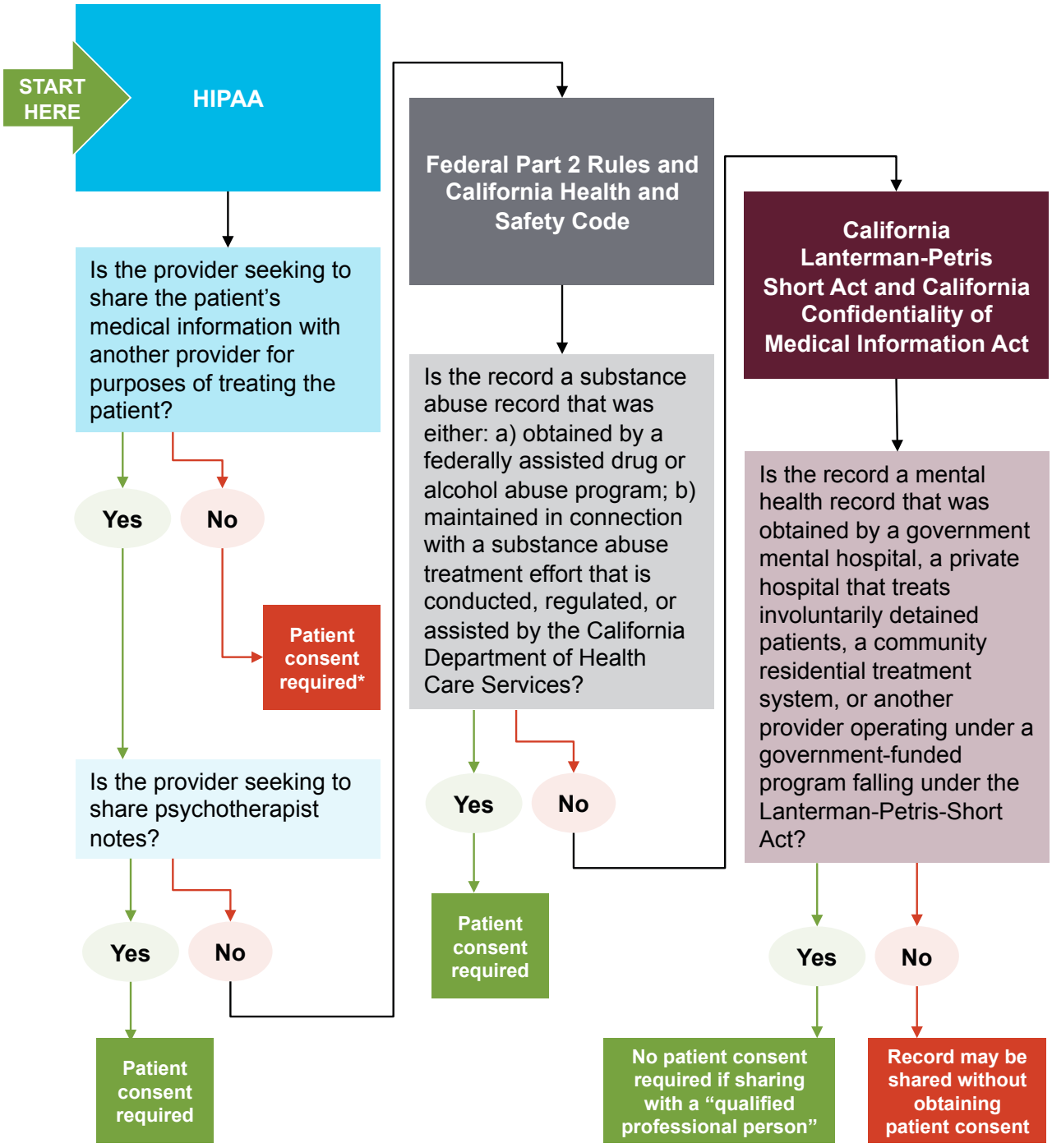
Federal Law

HIPAA

The Privacy Rule issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts covered entities such as health care providers and health plans from using or disclosing an individual patient's protected health information without his or her written authorization.[3] While health care organizations seeking to exchange patient information to improve quality or control costs often raise concerns about HIPAA, it is rarely a legal obstacle to achieving these objectives. This is because HIPAA contains broad exceptions that permit the use or disclosure of protected health information without the patient's authorization for treatment, payment, and health care operations.[4] Health care operations include care management and quality-improvement activities such as outcomes evaluation and development of clinical guidelines.[5]

Unlike some of the other privacy laws discussed below, HIPAA applies the same standards to all protected health information, whether related to behavioral or physical health services. The primary exception to this rule relates to psychotherapy notes, which generally may not be disclosed for treatment, payment, or health care operations

Figure 1. Sharing Behavioral Health Medical Records in the Course of Treating Patients



*Patient consent would not be required if the information was being shared for another purpose allowed under HIPAA, such as for payment or health care operations.

Sources: 45 C.F.R. Parts 160 and 164, 42 C.F.R. Part 2, California Civil Code Section 56, California Welfare and Institutions Code Section 5328, California Health and Safety Code Section 11845.5.

without the client's authorization.[6] Psychotherapy notes are notes of counseling sessions recorded by a mental health professional that are maintained separately from the rest of the individual's medical record.[7] Given the fact that providers rarely seek to share psychotherapy notes with one another, the exception does not serve as an obstacle to most data exchange initiatives.

HIPAA provides a baseline level of protection for behavioral health information, meaning providers in a state must comply with its privacy protections even if the state's privacy law protections are more lenient than HIPAA. But HIPAA does not pre-empt state or federal laws that provide stronger privacy protections, such as laws that require individual consent or authorization before certain types of more sensitive health information can be disclosed.[8] Thus, it is necessary to evaluate applicable federal and California laws and regulations that may be more stringent than HIPAA.

Part 2 — Substance Abuse Records

Federal regulations at 42 C.F.R. Part 2 impose stringent restrictions on the disclosure of identifiable patient records by "federally assisted alcohol and drug abuse treatment programs." Part 2 programs are generally those that are specially licensed to provide, or hold themselves out to the public as providing, substance abuse treatment services.[9] For example, a methadone clinic is subject to Part 2 but a general hospital is not, even if the hospital's emergency department provides detoxification services. Most programs that hold themselves out to the public as providing substance abuse services qualify as being federally assisted, since the definition of federal assistance is extremely broad: It includes both providers that receive any federal funds or federal tax benefits (such as tax-exempt status) as well as providers licensed by a federal agency (such as providers certified under Medicare). While the Part 2 rules apply directly only to Part 2 programs, any party that receives information from such a program must also comply with Part 2 if it seeks to disclose that information to someone else.[10]

There are very few exceptions under Part 2. One exception covers disclosure in a medical emergency, but there is no general treatment exception. There is also no exception for quality improvement or care management.

Absent an exception, any identifiable information from a Part 2-covered program ("Part 2 data") may be disclosed only with the patient's written consent. Part 2 data includes any information that identifies an individual as a drug or alcohol abuser, including his or her receipt of services from a Part 2-covered program as well as diagnoses and treatment plans related to substance abuse. The Part 2 rules specify the elements of a valid consent form. Among other things, the consent must explicitly name the individual or entity authorized to receive the Part 2 information.[11] A description of a class of individuals or entities (such as "all providers participating in the XYZ Health Information Exchange") is insufficient for this purpose.[12]

Sharing Medical Information — Two Patients

Mr. Jones was in a California county mental hospital, where his care providers noted his uncontrolled hypertension and referred him to a federally qualified health center (FQHC) for treatment upon discharge. They wanted to forward his medical records, including his medication list, to the FQHC. At the urging of county counsel, the hospital first obtained Mr. Jones' written authorization on a paper form approved by counsel. However, because the hospital's EHR system is not compatible with that of the FQHC, there was no simple process for making this information available electronically.

Ms. Smith, who is homeless and without a regular health care provider, was treated for substance abuse at a California hospital. Because she is overdue for a number of diabetes well-care exams, the hospital staff provided her with information on several clinics that would be willing to see her. They wanted to send Ms. Smith's records to her next care provider, but without knowing which specific provider will treat her, they are not sure whether they can get the appropriate legal authorization for forwarding the records.

In addition, the hospital is concerned that they cannot send Ms. Smith's information digitally — even though the hospital and the clinics are all using EMR systems that have been federally certified — because neither the system used by the hospital nor the ones used by the clinics has the capability to flag the substance abuse treatment information as sensitive and subject to laws requiring specific authorization to disclose the information.

California Law

California's privacy laws largely follow the pattern of federal privacy laws. Most types of clinical information, including mental health records, typically can be exchanged between providers for the purpose of treating the patient. But there are greater restrictions on the disclosure of substance abuse treatment records, which generally may be shared only with patient authorization. These regulations apply to various types of providers of physical and behavioral health care and do not vary based on the source of payment for that care.

Confidentiality of Medical Information Act

Outpatient mental health treatment provided by private (non-governmental) clinics, including federally qualified health centers (FQHCs), is typically subject to California's general privacy statute, the Confidentiality of Medical Information Act. The CMIA mirrors HIPAA in many respects. Like HIPAA, the CMIA treats medical information as confidential and prohibits its disclosure unless a specific exception under the law applies. For providers seeking to integrate care, an important exception allows providers to disclose information without the individual's authorization to other providers, health plans, or contractors (which includes independent practice associations and pharmacy benefit managers) for purposes of diagnosis or treatment.[13] Consequently, mental health providers who are not subject to more restrictive state privacy laws (see below) may share information for treatment purposes to the same extent that physical health providers may share treatment information.

Lanterman-Petris-Short Act

The Lanterman-Petris-Short (LPS) Act, rather than the CMIA, governs the exchange of patient information by some mental health providers. The LPS Act applies to federal, state, and county mental hospitals; institutions that treat involuntarily detained mental health patients; and residential programs such as mental health rehabilitation centers and community residential treatment systems.[14] The LPS Act can also apply to outpatient providers to the extent they participate in certain government-funded programs covered under the Act, such as gambling treatment programs, homeless outreach programs, or the provision of care to judicially committed people under the Forensic Conditional Release Program.

Like HIPAA and the CMIA, the LPS Act contains an exception that allows for the exchange of mental health information for treatment purposes. "Qualified professional persons" may share patient medical information with one another in the course of providing services without obtaining patient consent.[15] The statute does not define a "qualified professional person." This language is potentially narrower than the language in the treatment exception of the CMIA, which makes clear that a provider may share information with a broad range of health care organizations and professionals treating the patient.[16] At a minimum, the LPS Act allows a health care professional to share patient information with another health care professional who treats that patient, even if the two professionals work at different facilities or locations.[17]

In practice, the exception appears to be interpreted more broadly to permit the sharing of information by mental health facilities or programs at the organizational level, with access by nonprofessional personnel who provide support for the professional's activities. Indeed, given the way in which data are shared between institutions, there may be no other practical way to interpret the exception. But the precise scope of the exception is subject to interpretation, and this lack of clarity likely leads to different interpretations across the state with respect to the type of sharing that is permitted. As noted below, existing California initiatives have implemented different approaches to sharing mental health data, with some requiring prior patient consent and some not.

The LPS Act allows information to be exchanged pursuant to a patient's consent but is silent as to the form of consent needed.[18] The CMIA, however, does prescribe the form of consent and therefore serves as a useful guide for mental health providers even where the LPS Act rather than the CMIA is technically applicable. Among other requirements, the CMIA mandates that the consent form describe the functions of the disclosing party and the recipient of the information, explain the use and limitations of the information disclosed, provide an end date of the authorization, and be executed by a signature that serves no other purpose than to execute the authorization.[19]

Alcohol and Drug Abuse Treatment Records

In contrast to the general flexibility granted to providers when sharing mental health information, California's substance abuse law is stricter than its mental health law when it comes to the disclosure of records. California's statute governing alcohol and drug abuse programs

requires records relating to those programs to be kept confidential except under limited circumstances.[20] A qualified professional employed by a substance abuse program may share a patient's records with other professionals employed by the same program without obtaining the patient's consent. But if the practitioner seeks to share the information with others working at a different program, generally the patient's consent will be required except in limited circumstances such as in a medical emergency.[21]

These restrictions apply to any alcohol or drug abuse "treatment or prevention effort or function conducted, regulated, or directly or indirectly assisted" by the California Department of Health Care Services (DHCS).[22] This provision mirrors the language of the federal Public Health Service Act that is the basis for the Part 2 rules, but with one key difference: the federal law applies to substance abuse treatment regulated or assisted by a federal agency, not treatment assisted or regulated by DHCS.[23] Thus, a private substance program that is not federally assisted is subject to California's substance abuse privacy rules if it is licensed by DHCS.[24]

Historically, many hospital emergency departments, FQHCs, and other providers that offer limited substance abuse treatment have not been covered by California's substance abuse privacy law. Prior to 2013, it was the California Department of Alcohol and Drug Programs (ADP) that was responsible for regulating and funding the state's substance abuse programs. At the time, California's substance abuse privacy protection applied to programs that were "conducted, regulated, or directly or indirectly assisted" by ADP. Since many providers were not regulated or funded by ADP, they did not fall within the scope of this rule. In 2013, however, California transferred all of ADP's powers to DHCS, and statutory references to ADP were changed to references to DHCS.[25]

While the number of providers funded by ADP was relatively small, the universe of providers supported by DHCS is much larger, since DHCS is the agency responsible for administering Medi-Cal. Presumably, the state did not intend to expand the scope of its substance abuse privacy protections in making this administrative change. Nevertheless, the switch introduces uncertainty as to whether hospital emergency departments and other providers who occasionally treat patients for substance abuse must comply with the state's substance abuse privacy protection law.[26]

Given the restrictions in California's substance abuse privacy provision, California providers will often need to obtain an individual's consent prior to sharing his or her substance abuse treatment record with another provider, even in cases where the two providers jointly manage the patient's care. California law requires that the consent be in written form and identify the purposes for the release of the protected information and the circumstances under which the information can be released.[27] California law does not specify whether a patient can agree to a program's disclosure to multiple providers through the signing of a single consent form, but the statute's similarity to federal law suggests that the same Part 2 restrictions apply.

Moreover, if the program is subject to Part 2, the provider would have to comply with the consent form requirements of Part 2 rules anyway.[28] The lack of flexibility in the federal and state rules governing the sharing of substance abuse treatment data has made the sharing of this data a daunting challenge.

Minors

California's privacy laws do not distinguish between minor and adult medical information in regards to providers sharing medical records for treatment.[29] Thus, providers that are delivering mental health care or substance abuse care to a minor can share the child's medical records with other providers under the same circumstances under which such sharing is allowed for adult patients.

When providers treat a minor, they often confront the issue of whether they may share medical records with the minor and/or the minor's parent or guardian. For most types of medical treatment, it is the parent or guardian who grants consent to the minor's treatment, and therefore providers may disclose a minor's medical information and records to the minor's caretaker. However, minors who are 12 or older may consent to mental health care if the provider determines that "the minor is mature enough to participate intelligently in the mental health treatment or counseling services."[30] Minors who are 12 or older also may consent to substance abuse care.[31] In cases where minors who are authorized to consent for services, it is the minor, not the parent or guardian, who has a right to review the treatment records.[32] Nevertheless, even in these circumstances, providers are supposed to involve the parent or guardian in the minor's treatment plan if appropriate.[33]

Examples of Existing Initiatives

In each of the initiatives described below, mental health treatment data are made available to physical health providers, although each initiative is using a different approach, and consent is obtained in two of the initiatives but not in the other. All three continue to face challenges in sharing substance abuse treatment data and in achieving sharing that fits within provider workflows and that lays the foundation for a team-based approach to coordinated mental and physical health care.

Council of Community Clinics, San Diego County

The Council of Community Clinics (CCC) is a coalition of 16 private, nonprofit clinics that provide primary care and behavioral health services to one in six San Diego County residents.[34] Integration of physical and behavioral health is a priority for CCC, and it has had initiatives to integrate behavioral and physical health care in place for more than seven years. CCC began with a county contract, supported by funding from the California Mental Health Services Act (MHSA), which involved embedding behavioral health professionals in FQHCs to address the behavioral health needs of their patients. After some success with this model, CCC received funding from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to do "reverse integration," embedding primary care professionals in behavioral health programs to screen patients receiving specialty mental health treatment for serious physical illnesses, with a goal of reducing the 25-year mortality disparity for people with severe mental illness. The sharing of data under these initiatives took place by giving the participating professionals staff credentials to access the medical records used at the facility or location where care was provided.

Some CCC clinics have begun sharing behavioral and physical health data across disparate entities more recently. This sharing occurs largely through faxes between mental health providers and primary care entities, mostly FQHCs. The CCC clinics use a consent form approved by county counsel that the individual executes either upon discharge from a mental health facility, or as part of a care transition. (See Appendix A for San Diego County consent form.) The form covers the sharing of data between a designated mental health provider or provider organization and a designated physical health provider or provider organization; consequently, these providers or provider organizations are identified in advance of any sharing of data between the designated entities. The patient also is required to identify the particular types of data that are allowed to be shared. In circumstances where patients do not sign this consent to share information, the sharing does not occur, although representatives of CCC note that this rarely happens. In the words of one CCC representative, "When you have the trust of the patient, they usually sign the consent forms."

As noted above, this information is being shared on paper. The county requires its funded behavioral health programs to use a particular EHR system, Anasazi, which does not interface with EHR systems used by other providers. As a result, summary-of-care documents generated by physical medical providers, such as those participating in the federal EHR incentive program, cannot be shared by or with mental health providers funded by the county.

Although the completion of this consent form provides a level of comfort that such sharing is in compliance with applicable law, whether information is actually shared and then used in care is another challenge, as traditionally separate payment streams for mental/behavioral health and for physical health neither reward nor expressly pay for care integration or coordination.

CCC also has funding from Blue Shield of California Foundation for two integration pilots. The first pilot involves nurses from one FQHC and from one specialized mental health program developing shared care plans for patients being seen in both locations to ensure that providers at both sites have complete and accurate records. The goals of the pilot are to improve quality of care and reduce redundancy and cost of care. The second pilot targets transitioning stable patients from a specialty mental health program to one of three FQHCs for ongoing behavioral health care as well as primary care. Once stable, the patient is asked to choose a primary care location from a list of three participating FQHCs. A behavioral health professional from the FQHC then visits the patient at the specialty mental health program to ensure the patient is ready, explain how care is delivered at the FQHC, and give the patient an opportunity to meet someone from the FQHC prior to the transition.

In both of these pilots, the patients execute a short, one-page consent form that enables the sharing of data between the specialty mental health provider, the FQHC, and CCC (which collects and analyzes the data). (See Appendix B for Blue Shield consent form.) Because both pilots provide funds specifically to support integration, the data sharing necessary to enable that integration occurs as well.

The above initiatives of CCC focus on sharing of mental health data for adult patients, as those are the patient populations served by CCC's clinics. In addition, these initiatives do not involve the sharing of information covered by state or federal substance abuse treatment regulations because of their additional restrictions on data sharing.

For the past five years, CCC has operated an "Integration Institute" to further break down the barriers between behavioral and physical health providers and to encourage greater dialogue. The Integration Institute includes annual summits at which substance abuse, mental health, and primary care providers attend break-out sessions to advance clinical knowledge and learn about strategies for how to better work together. As part of the Integration Institute, CCC also pulls together regional "learning communities" — regional cohorts of providers who share ideas and lessons learned on how to work across systems to integrate. The communities focus on referral patterns within a region and often meet at a particular site, so they can learn how their peers work and strategize on-site on how to develop and sustain these relationships. In evaluations of Integration Institute activities, it is clear the providers are interested in sharing data.

Alameda County

Alameda County has a data sharing initiative focusing on the severely mentally ill, who frequently have serious or chronic physical medical conditions and poorer physical health outcomes. This effort is part of the county's "10 by 10" campaign, launched in 2012 and aimed at increasing life expectancy for mental health consumers by 10 years within 10 years.

Alameda County has access to claims data for uninsured people because the county pays for their care. The county receives claims data from specialty mental health providers through a secure flat file, and then processes and makes the information available in an Excel file for a patient's medical home, to improve care continuity and quality. The medical home provider can decide whether to scan or manually enter this information into its EHR. Medical home staffers are provided credentials to access this information from the server — a familiar process, since they regularly access physical health reports from other providers using this process. With a similar focus on care coordination, they also are sharing discharge summaries from acute psychiatric hospitals with medical homes, although this is not occurring as consistently as the sharing of ambulatory care information.

Under this initiative, providers exchange only data that can be shared legally in California without consent or authorization of the patient. According to Alameda County officials, these data include: (1) information from general health care providers, including information about mental health, HIV/AIDS and other sexually transmitted diseases, because HIPAA and California law permit this information to be shared and (2) the same broad scope of information from mental health providers, because California law permits this information to be shared with other health care providers who have "medical or psychological responsibility for the patient." Information from drug and alcohol treatment programs, including those subject to Part 2, is not part of this initiative, because it may only be shared, absent authorization from the patient, within the same program, except in the case of a medical emergency.

The county relies on a policy matrix approved by the Alameda County counsel to guide their actions. (See Appendix C for Alameda County policy matrix.) Although county leadership has endorsed this approach, and information sharing with medical homes is occurring, there are ongoing discussions among clinical professionals and patient advocates about what role patient consent should play in authorizing the sharing of this data, even in circumstances where it can be legally shared without express consent. There are concerns about stigma, and disagreements over whether those concerns are best honored by providing patients with choices about sharing sensitive data or exacerbated by treating this information as more sensitive than other health information. In the view of one county mental health professional, allowing patients to have choices about sharing behavioral health data, and requiring that they either exercise their choice in advance or opt out of such sharing, may create obstacles to sharing the data that are most needed for quality and care coordination.

This initiative is being pursued with the county's uninsured population — but this population is dwindling. The recent expansion of Medi-Cal has reduced the number of uninsured in the county by about half. Most of those who remain uninsured are undocumented people, who are less likely to access mental health services. The county is building relationships with the largest Medi-Cal managed care plan serving the county, Alameda Alliance for Health, to launch a similar initiative to share claims data with medical homes.

Now that the data are being shared, the county is focusing on encouraging clinicians and professionals in medical homes to access and use the information. There are human elements involved in integrating this care and getting people to trust one another and to work together and see themselves as a team. Behavioral health providers are concerned about subjecting their patients to stigma; physical health providers are concerned that the receipt of mental health data creates expectations about how the data will be used, a commitment providers are concerned they do not have sufficient time and resources to consistently make.

One approach to assuring the information is accessed and integrated is to get one or two people at each primary care clinic assigned to pull behavioral health reports from the servers and assure that information is delivered to the relevant treating providers. The county is also trying a targeted approach, focusing on those behavioral health patients who have not had a medical visit over the past year. The county has also paid for primary care clinics to embed mental health professionals into the clinics so that, over time, these professionals will become a regular part of the care team.

Although most of the data that has been shared to date has been about adult patients seen by specialty mental health providers, these providers are also sharing data of adolescent patients. County counsel has advised that the mental health data of minors can be shared with treating providers.

Inland Empire Health Plan

Inland Empire Health Plan (IEHP) is a Medi-Cal managed care plan serving San Bernardino and Riverside Counties. IEHP recognizes the importance of integrated behavioral and physical health care; it is one of the first health plans to have a behavioral health department. To enable this integrated care, IEHP has created a secure portal where behavioral health care providers can deposit treatment plans, which include medication lists, for those beneficiaries for whom IEHP is the primary payer for behavioral health services. The beneficiaries' other treating providers can then view, download, or print those plans. To date, the portal supports one-way sharing of information from behavioral health care to physical health providers. It is separate from the providers' EHR systems; consequently, action outside of the EHR is required by both types of providers to assure the information is uploaded and subsequently accessed.

When behavioral health providers upload a treatment plan to the portal, they also are required to attest that they have the consent of the beneficiary to share the plan with other treating providers. IEHP allows a beneficiary's treatment plan to be accessed by any health care provider that, based on claims data already submitted, has established a treatment relationship with the patient (i.e., the patient is linked to that provider). IEHP makes a consent form available for behavioral health providers to use with patients, but those providers are free to use their own processes instead. (See Appendix D for IEHP consent form.) When beneficiaries decline to give consent for access to their treatment plans, the plans are still uploaded into the portal because that is necessary for the behavioral health providers to receive payment from IEHP. But access to the information is blocked for other treatment providers; looking for a treatment plan in the portal would show them nothing from behavioral health. In IEHP's experience, such access blocks are infrequent.

The behavioral health providers are motivated to include this information in the portal because doing so triggers payment from IEHP for the care they have provided. As a result, 100% of IEHP's behavioral health providers are participating. Although physical medicine providers receive an email indicating that a treatment plan is available for their patients, use of the portal by such providers has been fairly limited. IEHP speculates that the reasons for this are that (1) consulting an outside portal, even for care coordination, is not well integrated into providers' existing workflows, (2) there are insufficient financial incentives to motivate the extra effort needed, and (3) providers' medical record technology is unable to incorporate the care plans, possibly requiring the information to be kept in paper form, scanned, or manually uploaded into a treating provider's EHR. According to

one commenter, "physicians don't like changing their processes; it's much easier to just write the referral to someone else, and then they don't have to worry about it. It's hard to change that."

The behavioral health providers using this service are largely those who provide mental health services. Providers of alcohol and substance abuse treatment services not covered by Part 2 are permitted to use the portal; it is the responsibility of these providers to secure a California-compliant consent form from an individual prior to sharing identifiable information through the portal. Sharing substance use treatment data through the portal — or even by fax if the portal is not used — typically occurs only if the substance abuse treatment provider and the physical health provider have conferred to discuss the patient, have agreed in advance to share data, and have agreed to share only data that are not covered by Part 2. The portal can be used to share information on either adults or minors.

In addition to the portal approach, IEHP is working with Riverside County to embed behavioral health professionals in primary care clinics. The county has developed a consent form that individuals execute to enable the sharing of their mental health treatment information and HIV test results with specific health care providers or organizations. (See Appendix E for Riverside County consent form.) Uncertainty on the part of counsel about whether this form is legally sufficient is creating obstacles to use of this model, and this form, in San Bernardino County.

Lessons Learned

The initiatives described above demonstrate that mental health information can be shared by California health care providers for treatment and care coordination, although providers are using somewhat different pathways to achieve these goals. Whether consent of the patient is sought prior to such data sharing varies by initiative. CCC does not seek individual consent for data sharing in its initiative because the embedded professionals are considered to be internally accessing information on-site. By contrast, Riverside County has approved a consent form to support this sharing. Thus, two projects using essentially the same model of embedding professionals in care settings to assure integration are taking different approaches to consent.

CCC, Alameda County, and initiatives supported by IEHP also enable sharing of mental health information across disparate entities; again, whether consent is sought depends on the initiative. Alameda County has analyzed federal and California law and advised that the sharing of mental health information can take place without the need for consent, while CCC's data-sharing initiatives rely on obtaining patient consent for such sharing. IEHP's sharing portal requires behavioral health providers to attest that they have obtained the required consent from the individual prior to sharing information through the portal.

These different approaches to sharing mental health information are all arguably permissible under California law; which option works best may depend on legal interpretations of counsel and providers' comfort about sharing information without necessarily first obtaining consent.

Substance abuse treatment information, whether from a program covered by Part 2 or by California law, is either not being shared in these initiatives, or the sharing of that information is not actively promoted. The Part 2 prohibitions on re-disclosure without authorization, as well as the requirement to obtain authorization that is specific to a provider organization — and the reliance of California regulations on Part 2 — make sharing this data particularly difficult.

None of these initiatives has achieved seamless digital sharing of mental health information across disparate providers, largely due to the lack of interoperability of EHR technology. CCC clinics are faxing information across entities, or nurses in one of the pilots are developing shared treatment plans in telephone conversations. In Alameda County, specialty mental health providers upload flat files, which are processed and turned into Excel files and made available to a patient's physical medical home provider on a secure server. IEHP similarly supports a secure portal that enables behavioral health providers to upload documents for physical health providers to access. Each of these initiatives requires additional steps outside of an EHR system to make information available and subsequently to access it. Federal regulators are working to try to resolve the lack of interoperability among EHR systems, as described in more detail below. In the meantime, these workarounds at least begin to get information moving to support integrated mental and physical health care.

Each of the initiatives recognizes that barriers to information sharing go beyond the legal and the technical. Financial support for integrated care is critical, particularly when sharing requires additional effort due to technology or cultural barriers. For example, IEHP requires behavioral health providers to upload information into the portal in order to be paid for care, and participation by these providers is high, but physical health providers are far less likely to seek out the information in the portal. CCC initiatives to share information across disparate mental and physical health providers are supported by a grant from Blue Shield of California Foundation. CCC's Integration Institute programs also aim to chip away at the cultural barriers that prevent behavioral and physical health providers from adopting a team-based approach to integrated patient care.

Federal Efforts to Address EHR Interoperability

A 2012 survey of behavioral health organizations found that although 65% of respondents are using an EHR in at least some of their sites, only 21% reported being "all electronic" and only 11% could use EHRs in a way that would enable them to meet federal EHR incentive program requirements (behavioral health providers are generally not eligible for the federal incentive program).[35]

Although obstacles to the sharing of behavioral and physical health data for care coordination are not just about technology, participants in all three of the initiatives explored in this paper expressed frustration with the lack of interoperability between EHRs used by county mental health providers and EHRs used by physical health providers. Interoperability has been defined by the federal Office of the National Coordinator for Health IT (ONC) as "the ability of a system to exchange information with, and use information from, other systems without special effort on the part of the customer."[36]

Simply put, interoperability should enable easy sharing of behavioral and physical health data between disparate systems in such a way that new information received by a health care provider can be populated into its record system without additional manual processes or human intervention. The lack of interoperability among medical record systems purchased by health care providers participating in the federal "meaningful use" electronic health record incentive program is a major focus for ONC, and ONC has received public comments on a draft roadmap for achieving interoperability.[37] Issues of interoperability are magnified for health care providers who, in some circumstances, must obtain patient authorization prior to disclosing health information to assure legal compliance and may need to both record that authorization and in some cases pass it along to the recipient provider to facilitate exchange.[38]

The authorization requirements under Part 2, described above, pose a particular challenge for health information exchange, and California substance abuse treatment laws, which are similar to Part 2, apply to an even broader set of substance abuse treatment providers. As noted above, these laws require individual authorization for both the initial disclosure by the substance abuse treatment provider and any subsequent re-disclosure by the recipient physical health provider. Most physical health providers with electronic medical records today are using "certified electronic health record technology" as part of the federal incentive program;[39] however, this technology currently is not required to have the capability to honor Part 2 re-disclosure requirements.[40]

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has been working with ONC to pilot technological approaches to achieving compliance with Part 2, both for substance abuse treatment providers and for physical health providers. The Data Segmentation for Privacy (DS4P) pilots have demonstrated the ability to exchange summary-of-care documents using the documentation standard — the Consolidated Clinical Document Architecture, or Consolidated CDA — required for the federal EHR incentive program.[41] The DS4P standard, which has been adopted by HL7, the international health data standards body,[42] enables substance abuse treatment providers covered by Part 2 to send standard care summary documents that are flagged (using metadata tagging) to indicate that the information is subject to Part 2 and may not be re-disclosed without further authorization from the patient.

This technology, when present also in the receiving provider's electronic health record, enables that provider to view the information in the care summary document, but does not allow that document to be uploaded or "consumed" by the provider's electronic health record because the information, once it is parsed from the

document, could be inadvertently disclosed. Technology to enable the Part 2 "flag" to remain with the information, even after it has been accepted into another provider's electronic health record, is not yet in widespread use.

This method of exchanging records does not achieve full interoperability; however, the federal Health IT Policy Committee, which is an advisory body to ONC, called it an important first step toward achieving interoperability for information covered by Part 2 and urged ONC to include the technology as part of its electronic health record certification program.[43] ONC has recently issued a proposed EHR certification rule that would require the DS4P standard to be included in certified EHR technology.[44] SAMHSA reports that some substance abuse treatment programs are using DS4P and other technologies to begin exchanging information with other providers.[45]

Conclusions

- **Clarification of California's LPS Act would facilitate more consistent exchange of mental health information.** California law permits providers to share physical and mental health information with one another for treatment purposes without the individual's consent. Under both the CMIA and the LPS Act, providers engaged in organized data exchange initiatives in California should not have to obtain consent to share mental health information for treatment purposes — but the experience of initiative participants interviewed for this paper suggests there is not a universal, consistent understanding of the LPS Act. The state could ease the administrative burden on providers by clarifying that the LPS Act does not require patient consent for the sharing of mental health information. In addition, advocacy groups, foundations, and other public interest organizations could provide training to the state's providers on this issue.

- **Federal efforts to promote interoperability are critical to the broader sharing of mental health information.** Eliminating the legal uncertainties associated with sharing mental health information will not, by itself, cause physical and mental health providers to integrate. Patient consent is generally not the primary obstacle to sharing physical and mental health information in California: the most significant barriers are technological, operational, and financial. Achieving interoperability among disparate EHRs could make sharing of data more seamless. ONC has taken steps to facilitate interoperability by proposing that certified EHRs include the capability to segment documents containing sensitive substance abuse treatment information so that the further use and disclosure of these documents is compliant with Part 2 and other stringent privacy laws; stakeholders seeking to achieve greater exchange of this information could support these efforts. Substance abuse and mental health treatment providers, who generally are not eligible for federal EHR incentives, could also be provided with financial support to purchase EHR systems that are interoperable with the systems used by physical medicine providers. In addition, greater incentives to share could also help break down cultural and workflow barriers. These incentives could be provided by the state or federal government as well as private health care payers.

- **SAMHSA must interpret the Part 2 rules more flexibly to promote the sharing of most substance abuse treatment information.** Patient consent is the major obstacle to sharing substance abuse treatment information. The Part 2 rules are particularly difficult to satisfy because they require all Part 2 consent forms to identify the individual provider to whom records will be disclosed and prohibit re-disclosure to any provider not specifically listed in the consent. SAMHSA has recently expressed an interest in revising the Part 2 rules to better match the reality of modern health information exchange.[46] SAMHSA should use this opportunity to develop a more flexible consent model that facilitates multi-provider — rather than only one-to-one — data exchange. The experience of providers serving these patients is that they do consent to share information with treating providers when they are asked;[47] SAMHSA should enable patients to authorize broad treatment sharing when that is consistent with the patients' wishes. Given that California laws mirror Part 2, flexibility from SAMHSA should have a ripple effect on the state's interpretation of its law as well.

- **In the absence of additional flexibility from SAMHSA, providers can attempt to share substance abuse treatment information by developing data exchange models under which accessing (rather than disclosing) providers obtain patient consent.** A consent-to-access model enables the consent to be structured in a way that complies with Part 2 rules by specifying the accessing provider's name in the consent form. This model also places the obligation for obtaining consent on the provider who is treating or preparing to treat the patient and is therefore most motivated to access information in order to obtain a more complete picture of the patient's health. Disclosing providers may lack this immediate and pressing motivation. However, Part 2 would still require accessing providers to obtain further consent from the patient for any subsequent disclosures of Part 2 data.

Endnotes

1. *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*, (Washington, DC: National Academies Press, 2006), www.nap.edu.
2. *HIT Adoption and Readiness for Meaningful Use in Community Behavioral Health*, National Council for Community Behavioral Healthcare, June 2012, www.thenationalcouncil.org.
3. 45 C.F.R. Parts 160 and 164.
4. 45 C.F.R. § 164.506.
5. 45 C.F.R. § 164.501.
6. 45 C.F.R. § 164.508(a)(2).
7. 45 C.F.R. § 164.501.
8. 45 C.F.R. § 160.203.
9. 42 C.F.R. § 2.11.
10. 42 C.F.R. § 2.12(d)(2).
11. 42 C.F.R. § 2.31.
12. *Frequently Asked Questions: Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange (HIE), Question 18,* Substance Abuse and Mental Health Services Administration.
13. California Civil Code § 56.10(c)(1).
14. The LPS Act applies to information and records obtained in the course of providing services under several divisions of California's Welfare and Institutions Code. California Welfare and Institutions Code § 5328. The providers mentioned above are governed by these divisions.
15. California Welfare and Institutions Code § 5328(a).
16. California Civil Code §§ 56.05(d), (h), (m), 56.10(c)(1).
17. The statute also says that if the professional receiving the information works at a different facility than the professional providing the information, then the recipient must have "medical or psychological responsibility for the patient's care." California Welfare and Institutions Code § 5328(a). Presumably, if the information exchange occurs for purposes of treatment, then the professional receiving the information will have medical or psychological responsibility for the patient.
18. California Welfare and Institutions Code § 5328(b).
19. California Civil Code § 56.11.
20. California Health and Safety Code § 11845.5(a).
21. California Health and Safety Code § 11845.5(c).
22. California Health and Safety Code § 11845.5(a).
23. 42 U.S.C. § 290ee-3.
24. Nevertheless, California agencies may not recognize a difference between their law and the Part 2 rules. While California's substance abuse privacy provision gives DHCS the authority to require all substance abuse programs under its jurisdiction to comply with the state's substance abuse privacy law, in practice state regulations only require substance abuse programs to comply with the Part 2 rules and the more lenient privacy provisions of the LPS Act. See, for example, California Code of Regulations, Title 9, §§ 9866(c), 10155(a), 10568(c), 10569(a)(1), 11036.
25. California Health and Safety Code § 11751.
26. Unlike the federal Part 2 rules, there is no requirement that a provider "hold itself out" to the public as providing substance abuse care to fall within the scope of California's substance abuse confidentiality provision.
27. California Health and Safety Code § 11845.5(b).
28. California has a separate confidentiality provision that applies to state- and county-operated substance abuse programs, and programs that have a contract with a county. This provision allows substance abuse records to be disclosed in accordance with the LPS Act's rules. California Health and Safety Code § 11812(c). Since the LPS Act allows providers to exchange records without patient consent, this section is at odds with California's more general substance abuse provision, which generally prohibits such exchanges.
29. California Civil Code § 56.10(c)(1); California Health and Safety Code § 11812(c); California Welfare and Institutions Code § 5328(a).
30. California Health and Safety Code § 124260(b). A provision of California's family law, however, says that to consent to mental health treatment, the minor must demonstrate such maturity and must either "present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling or residential shelter services" or be "the alleged victim of incest or child abuse." California Family Code § 6924(b).
31. California Family Code § 6929(b).
32. A parent or guardian does not have the right to inspect a minor's patient records if the minor has a right of inspection to those records under Section 123110 of the Health and Safety Code (the parent or guardian also cannot view the records if the provider determines that access would have a detrimental effect on the minor's well-being or on the provider's relationship with the minor). California Health and Safety Code § 123115(a). Section 123110, in turn, gives minors the right to inspect patient records pertaining to "a type for which the minor is lawfully authorized to consent." California Health and Safety Code § 123110(a). In effect, these two provisions deny parents and guardians the right to view the medical records of their children that relate to services to which children are authorized to grant consent. See also California Civil Code § 56.11(c).

33. California Family Code §§ 6924(d), 6929(c); California Health and Safety Code § 124260(a).

34. "Overview," Council of Community Clinics, www.ccc-sd.org/overview.

35. *HIT Adoption and Readiness for Meaningful Use in Community Behavioral Health*, Chart 12, National Council for Community Behavioral Healthcare, June 2012, www.thenationalcouncil.org.

36. *Connecting Health and Care for the Nation,* Office of the National Coordinator for Health Information Technology, www.healthit.gov.

37. Ibid.

38. Ibid.

39. "Electronic Health Record Use Among Physicians Participating in Delivery Reform Programs," Office of the National Coordinator for Health Information Technology, August 2014, dashboard.healthit.gov.

40. See letter of July 15, 2014, www.healthit.gov.

41. "Data Segmentation for Privacy Homepage," S&I Framework, wiki.siframework.org.

42. "Project Summary for HL7 Data Segmentation for Privacy (DS4P) Implementation Guide," Health Level Seven International, www.hl7.org.

43. Letter of July 15, 2014, www.healthit.gov.

44. "2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications," 80 Fed. Reg. 16804 (March 30, 2015), federalregister.gov.

45. *SAMHSA's Investment in e-Systems Integration,* Substance Abuse and Mental Health Services Administration. Presentation at Hilltop Institute Symposium "Information Follows the Person," June 14, 2012, www.hilltopinstitute.org.

46. "Demonstration Program to Improve Community Mental Health Services (Section 223 of the Protecting Access to Medicare Act of 2014)," Substance Abuse and Mental Health Services Administration, www.samhsa.gov.

47. See infra summary of CCC in San Diego; see also letter of September 1, 2010, www.healthit.gov.

Appendix A: San Diego County Consent Form

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Coordination with Primary Care Physicians and Behavioral Health Services

Coordination of care between behavioral health care providers and health care providers is necessary to optimize the overall health of a client. Behavioral Health Services (BHS) values and expects coordination of care with health care providers, linkage of clients to medical homes, acquisition of primary care provider (PCP) information and the entry of all information into the client's behavioral health record. With healthcare reform, BHS providers shall further strengthen integration efforts by improving care coordination with primary care providers. Requesting client/guardian authorization to exchange information with primary care providers is mandatory, and upon authorization, communicating with primary care providers is required. **County providers shall utilize the *Coordination and/or Referral of Physical & Behavioral Health Form & Update Form*, while contracted providers may obtain legal counsel to determine the format to exchange the required information.** *This requirement is effective immediately and County QI staff and/or COTR will audit to this standard beginning FY 13-14.*

For all clients:

Coordination and/or Referral of Physical & Behavioral Health Form:

- Obtain written consent from the client/guardian on the *Coordination and/or Referral of Physical & Behavioral Health Form*/ contractor identified form at intake, but no later than 30 days of episode opening.
- For clients that do not have a PCP, provider shall connect them to a medical home. Contractor will initiate the process by completing the *Coordination and/or Referral of Physical & Behavioral Health Form* /contractor form and sending it to the PCP within 30 days of episode opening. It is critical to have the specific name of the treating physician.
- Users of the form shall check the appropriate box at the top of the *Coordination and/or Referral of Physical & Behavioral Health Form* /contractor form noting if this is a referral for physical healthcare, a referral for physical healthcare and medication management, a referral for total healthcare, or coordination of care notification only. If it is a referral for physical healthcare, or physical healthcare and medication management, type in your program name in the blank, and select appropriate program type.

Coordination of Physical and Behavioral Health Update Form:

- Update and send the *Coordination of Physical and Behavioral Health Update Form* /contractor form if there are significant changes like an addition, change or discontinuation of a medication.
- Notify the PCP when the client is discharged from services by sending the *Coordination of Physical and Behavioral Health Update Form* /contractor form. The form shall be completed prior to completion of a discharge summary.

Tracking Reminders:

- Users of the form shall have a system in place to track the expiration date of the authorization to release/exchange information.
- Users of the form shall have a system in place to track and adhere to any written revocation for authorization to release/exchange information.
- Users of the form shall have a system in place to track and discontinue release/exchange of information upon termination of treatment relationship. Upon termination of treatment the provider may only communicate the conclusion of treatment, but not the reason for termination.

LIVE WELL SAN DIEGO

Appendix B: Blue Shield Consent Form

Blue Shield Transition Pilot

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT/CLIENT		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:	SSN:	DATE OF BIRTH:

THE FOLLOWING ORGANIZATIONS ARE AUTHORIZED TO RELEASE and/or RECEIVE INFORMATON:

☐ UCSD/Gifford Clinic ☐ Council of Community Clinics	☐ Family Health Centers of San Diego ☐ La Maestra Community Health Center ☐ San Diego Family Care

THE FOLLOWING INFORMATION IS TO BE DISCLOSED: (PLEASE CHECK)

☐ Most recent Behavioral Health Assessment or most recent Behavioral Health Update
☐ Psychiatric assessment
☐ Information about medication regime over the last six months, history of keeping appointments, stability over the last six months, current living arrangement and insurance status

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Photocopy or Fax: I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section164.524.

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

SIGNATURE:	DATE:

The above signed authorizes the behavioral health practitioner and the physical health practitioner to release the medical records and Information/updates concerning the patient.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:
If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed, or 60 days after termination of treatment.

VALIDATE IDENTIFICATION ☐

SIGNATURE OF STAFF PERSON:	DATE:

Appendix C: Alameda County Policy Matrix

ALAMEDA COUNTY
HEALTH CARE SERVICES
AGENCY
ALEX BRISCOE, Director

AGENCY ADMIN. & FINANCE
1000 San Leandro Boulevard, Suite 300
San Leandro, CA 94577
Tel: (510) 618-3452
Fax: (510) 351-1367

Sharing Protected Health Information for Treatment Purposes

When allowed by law (see below), Protected Health Information (PHI) may be shared for treatment purposes across disciplines and programs on a "need-to-know" basis and for the purposes of improving health outcomes. PHI includes case management/coordination communication, medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment, results of clinical tests, and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. Individual practitioners and program staff in agencies that furnish health services in the normal course of their business are considered treatment or healthcare providers.

HIPAA defines treatment as "the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another." References: Civil Code 56.10(c)(1), H&S Code 123010, and HIPAA (45 CFR sec.164.506, 45 CFR 164.501 45, CFR 164.506).

Description of PHI	Who may disclose it?	Who may receive it?
General Health (includes knowledge of Mental Health, Substance Use/Abuse, HIV/AIDS, STD conditions)	General Health Provider	Patient's providers and providers' staff for the purpose of treatment, diagnosis, or referral *[Reference: Civil Code 56.10(a); HIPAA Treatment Exception]*
Mental Health (includes knowledge of General Health, Substance Use/Abuse, HIV/AIDS, STD conditions)	Mental Health Provider	Any healthcare provider (any discipline) "who has medical or psychological responsibility for the patient" *[Reference: W&I Code 5328(a); HIPAA Treatment Exception]*
Drug/Alcohol Treatment Program (includes knowledge of General Health, Mental Health, HIV/AIDS, STD Conditions)	Drug/Alcohol Treatment Program Provider	Only another member of the client's treatment team WITHIN the specific drug/alcohol treatment program Exception: a medical emergency *[Reference: 42 CFR Part 2, section 2.12 (c)(3)]*

Adapted from San Francisco Department of Public Health Privacy Policy Matrix by permission.

Appendix D: Inland Empire Health Plan Consent Form (2 pages)

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:**
_____ (Health Care Provider / Organization to **release** information)	_____ (Health Care Provider / Organization to **receive** information)
_____ (Address)	_____ (Address)
_____ (City, state, zip code)	_____ (City, state, zip code)
_____ _____ (Phone Number) (Fax Number)	_____ _____ (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:_____

Authorization for Use and/or Disclosure of Patient Health Information

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

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

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.

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.

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

Appendix E: County of Riverside Consent Form (2 pages)

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:**
_____ (Health Care Provider / Organization to **release** information)	_____ (Health Care Provider / Organization to **receive** information)
_____ (Address)	_____ (Address)
_____ (City, state, zip code)	_____ (City, state, zip code)
_____ _____ (Phone Number) (Fax Number)	_____ _____ (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:_____

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

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

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

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.

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.

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