INSTRUCTIONS FOR MODEL AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION:

Across the country, counties are working to better understand and serve their "familiar faces" who are individuals with mental health disabilities, often with co-occurring substance use or physical health conditions, who cycle repeatedly through the county's homeless shelters, emergency rooms, and jails. In order to identify and break these patterns, better information sharing between justice and health stakeholders is key. Law enforcement officers, medical providers, and others who encounter these Familiar Faces in emergency rooms, jails, outpatient clinics, shelters, or elsewhere often lack sufficient information about these individuals and their behavioral health service histories. Without adequate information about their conditions and needs, service providers may struggle to divert Familiar Faces away from restrictive facilities and towards appropriate care. Ultimately, this gap slows or prevents people from obtaining the services they need and creates a financial burden on counties who must maintain expensive services, including jails and hospitals.

The key to better information sharing about the treatment histories of people with mental health disabilities involved in the criminal legal system is ***to get their informed consent*.** Agencies who are required to comply with the Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule, or similar state privacy laws, should obtain informed consent from their patients in order to remain in compliance with the law. Consent for information sharing can be secured by informing individuals about the importance of health service coordination in providing appropriate care, the obligations of recipients of the information to preserve confidentiality, and an individual's rights to control the types of information to be shared. If an individual chooses to provide informed consent, confidential medical information, including information about a person's mental health symptoms, medication use, and other treatment history, can be disclosed among select justice stakeholders and health service providers to better identify and serve Familiar Faces in their community.

Purpose

This model authorization for release of health information is designed for use by service providers to obtain informed consent from people with mental health disabilities to share their medical and mental health records among criminal justice and behavioral health agencies and service providers.

Law enforcement officers, a pretrial case coordinator or a service provider can work with an individual to help them understand how and why information about their mental health diagnoses, service histories, social and family histories, and medications may be shared among certain designated agencies. The model authorization includes fictional agency and provider names but can be modified to include the names of actual entities within the jurisdiction.

In order to obtain an individual's informed consent to share their private health information, service providers who use this form should be transparent about the types of information sharing. In some jurisdictions, the individual must provide express informed consent to sharing alcohol/drug treatment information, mental health treatment information, and HIV/AIDS-related information. If your jurisdiction does not require express consent to these three categories or requires express consent to disclosure of some other category of information, this form may be modified to reflect legal requirements in your state or locality.

Gaining Consent

The person who is helping the individual complete the form should read the statements in sections (1)-(5) aloud and ensure that the person provides verbal confirmation that they understand each of these statements.

Ask the individual when they would like the authorization to exchange information to expire. In some jurisdictions, the default period after which an authorization can expire is one year, therefore the individual must reauthorize their consent to information sharing after that time frame.

The individual completing the form should indicate that they understand the outcomes and potential consequences of information sharing.

NACo would like to thank Lewis Bossing, Bazelon Center for Mental Health Law, for his work in creating this document. This resource was created for the Familiar Faces Initiative with support from Arnold Ventures.

MODEL AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Name:	Date of Birth:	Client No.:
Address:		

I authorize the County Department of Behavioral Health to exchange information with the following agencies:

◯ Alpha Services
◯ Bravo Housing Supports
◯ Charles County Department of Human Services
◯ Charles County Sheriff's Department
◯ Charles County Superior Court
◯ Delta Clinic
◯ Echo Center for Recovery
◯ Foxtrot Family Services
◯ Golf Community Hospital
◯ Hotel California House
◯ India Hospital Center
◯ Juliet Care Center
◯ Kilo Behavioral Health, Inc.
◯ Lima Outreach Services
◯ Mike Madison Memorial Hospital
◯ November Institute
◯ Oscar Center
◯ Papa, Inc.
◯ Other: _____
◯ Other: _____
◯ Other: _____

The reason for the exchange of the information is:

◯ At my request.
◯ Other: _____

The purpose for the exchange of information is to help with referral for housing or services programs or accommodations, and to help with determining eligibility for housing or services programs or accommodations.

The information to be exchanged includes the following:

◯ Physical Examination Records
◯ Psychological Evaluation
◯ Psychiatric Evaluation

◯ Hospital Admission, Treatment, and Discharge Records
◯ Outpatient Treatment Records
◯ Income Verification
◯ Other: _____
◯ Other: _____

If initialed below, the information to be exchanged also includes:

_____ **ALCOHOL/DRUG TREATMENT INFORMATION**
_____ **MENTAL HEALTH TREATMENT INFORMATION**
_____ **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**

The information to be exchanged is from (insert date) _____ to _____.

I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL and DRUG TREATMENT**, **MENTAL HEALTH TREATMENT**, and **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, but only if I place my initials on the appropriate line above. In the event the health information described below includes any of these types of information, and I initial the line on the box above, I specifically authorize release of such information to the agencies and programs listed above.
2. My medical information, including any alcohol and/or drug treatment records, is protected by federal regulation under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164. My alcohol and/or drug treatment records, if any, are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2.
3. With some exceptions, if health information is disclosed it may be re-disclosed by the agency that receives it. If I am authorizing the exchange of alcohol or drug treatment information, mental health treatment information, or HIV/AIDS-related information, the recipient may not re-disclose such information or use the disclosed information for any other purpose without my consent unless permitted to do so under federal or state law.
4. I have the right to revoke this authorization at any time by writing to the County Department of Behavioral Health. I may revoke this authorization except to the extent that action has already been taken based on this authorization.
5. Signing this authorization is voluntary, My participation in a housing or services program will not be conditioned upon my authorization of this disclosure.

DATE ON WHICH THIS AUTHORIZATION WILL EXPIRE: _____. I may revoke this authorization in writing at any time.

All items on this form have been completed and my questions about this form have been answered. I have been provided a copy of the completed form.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

NAME OF PERSONAL REPRESENTATIVE: _____

SIGNATURE OF PERSONAL REPRESENTATIVE: _____

DATE OF PERSONAL REPRESENTATIVE'S SIGNATURE: _____

PERSONAL REPRESENTATIVE EMPOWERED TO ACT BY:

_____