SAN BERNARDINO COUNTY
Behavioral Health

303 E. Vanderbilt Way San Bernardino | (909) 388-0900
www.SBCounty.gov

CHILDREN'S INTERAGENCY AUTHORIZATION TO EXCHANGE CONFIDENTIAL HEALTH INFORMATION (PHI)

Client's Name	
Case #	
Social Security # XXX-XX-	
Date of Birth	
Mother's Name	
Father's Name	

I authorize the multidisciplinary team to exchange the confidential health information of the above named child among the following team members in order to develop and implement a service plan.

☐	Children and Family Services
☐	Department of Behavioral Health (DBH) (Mental Health)
☐	Inland Regional Center
☐	Jobs &Employment Services Department
☐	Law Enforcement Agency (specify)
☐	Other (specify)
☐	Other (specify)
☐	Probation Department
☐	Public Health Department
☐	School District/SB Superintendent of Schools
☐	Transitional Assistance Department
☐	DBH Substance Use Disorder and Recovery Services (SUDRS) ***Note:*** Completion of this authorization only permits SUDRS to *receive Mental Health* treatment information. A separate 42 CFR Part 2 compliant Authorization for release of PHI (COM001) must be completed for a specific person, by name, at each agency to whom SUDRS treatment information is to be disclosed.

This authorization is limited to the following specific types of information:

I understand the following:

- I can cancel this authorization at any time except for action that has already been taken.
- Cancellation of this authorization must be *in writing* to the mental health staff of the team.
- If not cancelled earlier, this authorization shall terminate on .
- I have a right to refuse to sign, or to limit the scope of, this authorization.
- I understand the health information I authorized for release could be re-disclosed by the person/entity I designated to receive the information. I understand DBH cannot prevent my information previously released by this Authorization from being re-released by whoever received it.
- I understand in some cases California law does not prohibit the re-release of my information and my information may no longer by protected by federal confidentiality law (HIPAA). However, I understand California law prohibits the person or entity receiving my health information from making additional disclosures unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

I have read this authorization carefully and have had my questions answered.

Date Time AM ☐ PM ☐

Signature

(DBH client shall sign, including minor age 12 and up, if having legal and mental capacity)

Signature

(Legal representative of client or parent/guardian for minors not having capacity to consent)

Note: If signed by someone other than the client, state your name and legal relationship to the client (MUST provide legal documentation to support the legal relationship).

The treating physician, psychologist, LCSW or LMFT will sign if approval is needed under the Lanterman-Petris-Short Act (California W&1 Code Section 5328).