County of Santa Cruz

HEALTH SERVICES AGENCY
Behavioral Health Division
Substance Use Department
1400 Emeline Ave. Building K, Santa Cruz, CA 95060
Phone: (831) 454-7519 Fax: (831) 454-4770

CONSENT FOR SUBSTANCE USE DISORDER TREATMENT

I am requesting services from the Santa Cruz County Substance Use Disorders (SUD) Services Program (SUDS) system of care at _____.

I hereby acknowledge my consent to enrollment in substance use disorder (SUD) treatment.

- I understand that SUD treatment may include assessment and treatment planning, individual, family, and group counseling, SUD education, recovery skills training, drug testing, supervised/structured housing, and case management. In compliance with the confidentiality regulations described below, coordination may occur between County SUD Services, treatment funders, referring agencies, and/or professionals involved in my care including discharge planning, aftercare counseling, and recovery maintenance services.
- I understand that all information and records obtained and maintained in the course of providing treatment services are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations or authorized by me.
- I understand that Santa Cruz County SUD programs may need to disclose my information to my insurance provider for the purpose of *payment*, to allow my health care providers to get paid for the services they provide and figure out if I am eligible for services or benefits. I further understand that for the purpose of *health care operations*, such as administrative, financial, legal and quality improvement activities necessary for the organization to run its business and support my treatment and payment for my services, Santa Cruz County SUD programs may disclose my information. I authorize disclosures for these payment, treatment and operation purposes.
- I understand that I may report any dissatisfaction to the Quality Improvement Department, 1400 Emeline Ave., Santa Cruz, CA 95060, and (831) 454-4468. I may also report complaints to the State Department of Health Care Services Substance Use Disorder Compliance Division, P.O. Box 997413, MS# 2601, Sacramento, CA 95899-7413.
- I expressly acknowledge that all the information I have furnished upon intake is true to the best of my knowledge. I have received and read copies of the program rules, participant agreements and client rights, as provided to me by my treatment provider.
- I understand that I may revoke this consent at any time and have a right to receive a copy of this consent.
- I consent to being contacted by the program listed above post discharge for follow-up. _____ (initials)

Copy provided: ☐ Initials_____ ☐ Copy was offered but client refused: Initials_____

Client Printed Name: _____

Client Signature_____ Date_____

Witness/Staff Signature_____ Date_____