# County of San Bernardino
# Department of Behavioral Health

## CONSENT AND AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION FOR VETERANS STATUS

| | |
|---|---|
| Name of Client: _____ | Date of Birth: _____ Month/Day/Year |
| Sex: ☐ Male ☐ Female | Social Security: _____-_____-_____ |

**Completion of this document authorizes the release, disclosure, and/or use of health information about you. Failure to provide all information requested may invalidate this Authorization.**

By my signature below, I authorize the County of San Bernardino, Department of Behavioral Health (DBH), to release information to the San Bernardino County Department of Veterans Affairs (DVA) and the United States Department of Veterans Affairs (USDVA) for the purpose of identifying and/or assisting with the obtaining of veterans benefits and to authorize the DVA and the USDVA to release their findings to DBH. Information released shall be limited to only information that is necessary to verify veteran status and to verify/obtain benefits.

**Information that may be released includes:**

☐ Personally Identifiable Information
(i.e. social security number, name etc. **This is required in order to confirm veteran status.**)

☐ Diagnosis ☐ Presenting Problem

☐ Treatment ☐ Behavioral Health Status

**To Agencies Receiving This Information:**

This information is protected by state and federal laws and should not be given to anyone else not included on this Authorization without a new Authorization from the client, unless otherwise authorized by law. If you have received alcohol and/or drug assessment, treatment, or referral program information, the following applies: This information has been disclosed to you from records protected by Federal confidentiality law/rule (42 CFR, Part 2). The Federal rules forbid you from making another/any further release/disclosure of this information unless expressly/specifically permitted by Federal law/rule (42 CFR, Part 2). A general Authorization of medical or other information is NOT sufficient for this purpose. The Federal laws/rules restrict

any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

## Expiration

This Authorization expires [insert date]: _____

## Client rights

- You may refuse to sign this authorization; however, it may hinder the ability for the provider to attain benefit information for your benefit.
- You have the right to receive a copy of this authorization.
- To the extent permitted by law, you may inspect or obtain a copy of the health information that you are being asked to allow the use or disclosure of.
- You may revoke this authorization at any time, but you must do so in writing to:

  _____
- Your revocation will take effect upon receipt of the written request, expect to the extent that others have acted in reliance upon this authorization.

Information released by this authorization could be re-released by whoever receives it, and the re-release is in some cases not protected by California law and may no longer be protected by federal confidentiality (HIPAA).

## Signature

Date: _____ Time: _____ am/pm

Signature: _____
*(client/representative/spouse/financially responsible party)*

If signed by someone other than the client, state your legal relationship to the client:

_____

Witness: _____