San Francisco
Department of Public Health

Written consent forms for BEAM Telehealth and Navigation program for Medications for Opioid Use Disorder

What is this form?

The SUD Universal Consent form indicates that you are giving permission for SFDPH providers to document and access information related to substance use (drug and alcohol use) treatment.

Why am I signing it?

We want to ensure you agree and consent to receiving treatment and understand your rights. They are important forms for you to review and sign to indicate your awareness of how your medical information will be used and shared within SFDPH to provide you with the safest and best care. If you have questions about the content or purpose of these forms, please ask the BEAM Navigator, BEAM Telehealth Provider or reach out to telemoud@sfdph.org.

What do I do after I sign this form?

You can return this form in two ways:

1) By fax using the attached coversheet
2) By secure email to telemoud@sfdph.org with "Secure: Consents" in the subject line

San Francisco
Department of Public Health

Medical Facsimile Cover Sheet

TO:

Name:	Remi Franklin BEAM Telehealth and Navigation for Medications Administrative Coordinator
Phone	628-754-9154
Fax:	628-754-9581

FROM:

Name:	
Signature:	
Phone:	
Fax:	
Date:	

CONFIDENTIAL

Confidential Health Information Enclosed. This protective cover sheet is in compliance with the Health Insurance Portability and Accountability Act (HIPAA). As health information is personal and sensitive, you the recipient are obligated to protect the confidentiality of this transmission. This transmission has been sent after obtaining authorization from the individual or under conditions where the individual's authorization was not required. Law prohibits re-disclosure of these documents without obtaining additional consent or authorization by the individual. **Unauthorized redisclosure of these documents or failure to keep these documents safe, confidential, and secure can subject you to penalties under Federal and/or State Law.**

This facsimile transmission is intended for the sole confidential use of the designated recipients, some or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule. If you have received this information in error, any review dissemination, distribution, or copying of this information is strictly prohibited. If you have received this transmission in error, please contact the sender to arrange for the destruction or return of the information. If any pages failed to send, please contact the sender at the above number.

SF Department of Public Health
SF Health Network

PERMISSION TO SHARE YOUR SUBSTANCE USE DISORDER (SUD) TREATMENT NOTES

NAME
DOB
MRN
Patient Label/Information

The San Francisco Department of Public Health (DPH) is committed to providing you with the best possible care. Our clinical team members need to understand all your medical history and care within DPH so they can offer you the safest and best care. To do this, we are asking your permission to share all information related to substance use (drug and alcohol use).

Completion of this document means you are giving permission to the use and/or disclosure of your substance use disorder information, as detailed below, according to California and federal law. Please provide all information marked with an asterisk (*) otherwise this authorization is not valid.

***Name**_____

***Date of Birth**_____ **MRN/BIS#** _____

Who can share and Receive my Personal Substance Use Information

I authorize (select one of the following*)

_Initials_____ All Users of SFDPH Electronic Health Records (EHR)
This includes but is not limited to providers and authorized staff at DPH, UCSF and other DPH community partners

OR

__Initials_____ In addition to the above, I ALSO consent to having my substance use notes shared via a health information exchange, such as Epic CareEverywhere. This exchange would allow other health care organizations or providers where I get care to have access to my substance use notes**.**

What will They be Sharing

I understand that some information must be documented and shared in the DPH Electronic Health Record (EHR), such as medical diagnoses, medications, allergies, immunizations, and test results. **This information is shared across clinical care teams using the DPH Electronic Health Record (EHR)**. This clinical information cannot be blocked from being shared.

I understand that my substance use (drug and alcohol) information can be used for the purpose of substance use disorder treatment, payment and operations; care coordination and quality improvement.

How long am I giving my Permission to Share this Information

I understand that I may revoke this authorization at any time. Unless I revoke my consent earlier, this consent will expire automatically upon ten (10) years after the date of my death.

Redisclosure – Telling my Information to Someone Else

If health information is disclosed to someone who is not legally required to keep it confidential, it may be redisclosed (told to someone else) and may no longer be protected. This is a California law.

MY RIGHTS

- I may decide not to sign this authorization.
- I may revoke (change my mind about) allowing sharing of my SUD information at any time. Changing my mind must be in writing, signed by me or on my behalf by someone with the legal authority to do so and delivered to my provider site.
- My revocation (changing my mind) will be effective when my provider site receives it, but I understand my information that has already been shared cannot be taken back.
- I have a right to obtain a copy of this authorization.
- **If I refuse to consent to a disclosure, I will still receive services.**

*Signature: _____ *Date: _____

Parent/Guardian/Conservator Signature: _____

Interpreter ID: _____Witness:_____

NOTE TO RECIPIENT OF SUD INFORMATION:
Pursuant to Section 2.32 of 42 CFR, the following notice is also provided:
Federal law/42 CFR part 2 prohibits unauthorized disclosure of these records**.**

SFDPH Use Only: Patient has declined to sign this Permission Form. I have discussed this form and have answered the patient's questions. Patient has been informed that certain clinical information will be shared by all providers. Patient appears to understand our discussion and wishes to receive care.

Provider Signature_____ Date: _____