CARE PLUS PROGRAM (CPP)
AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

The Care Plus Program is designed to improve health outcomes by coordinating care among Participating Entities through information sharing. Your authorization to share your information will allow Care Plus Program Participating Entities to disclose to each other confidential information including personally identifying information and protected health information that pertains to you for purposes of coordinating your care. The Participating Entities will utilize tools including the System of Care Data Integration System ("SOCDIS") platform in the Care Plus Program to share your information. Please read the additional information attached to this form and found at https://ceo.ocgov.com/care-coordination/care-plus-program about the Care Plus Program, the Participating Entities' disclosure, receipt, use, and protection of your information, and the SOCDIS platform.

PART 1: INDIVIDUAL INFORMATION

Client/Patient Last Name	Client/Patient First Name	Middle Initial

Date of Birth	Email (optional)	Telephone Number with Area Code(optional)

Address (optional)	City	State	Zip

PART 2: ENTITIES THAT WILL **DISCLOSE** YOUR INFORMATION:

THE PARTICIPATING ENTITIES			Address: 601 N. Ross St., 5th Floor
City: Santa Ana	State: CA	Zip: 92701	Telephone Number with area code: (714) 834-5000

PART 3: ENTITIES THAT WILL **RECEIVE** YOUR INFORMATION:

THE PARTICIPATING ENTITIES			Address: 601 N. Ross St., 5th Floor
City: Santa Ana	State: CA	Zip: 92701	Telephone Number with area code: (714) 834-5000

PART 4: PURPOSE OF THIS AUTHORIZATION

The Participating Entities listed in this form will use the information you authorize them to share for the purposes of coordination of your care to improve your health and well-being. These services may be in areas like medical care, mental health care, drug and alcohol treatment, housing, employment, public benefits, education, nutrition, parenting, and child welfare.

PART 5: INFORMATION YOU AUTHORIZE THE PARTICIPATING ENTITIES TO DISCLOSE TO EACH OTHER

By signing this form, you are authorizing the Participating Entities listed in this form to disclose to each other past, present, or future personally identifying information and protected health information that pertains to you for the purpose of coordinating your care. This information may be written or verbal and includes the following: name, date of birth, social security number, demographics, contact information, citizenship/legal residency status, history of housing and homelessness, veterans status and benefits, welfare, social security and other public benefits, financial information, wage and income information, probation status, correctional institution history, court involvement, health and emergency services including medical history, mental or physical condition and treatment received, drug or alcohol use including any related diagnosis and treatment, disability information, and any additional information that would assist the Participating Entities in coordinating your care.

Disclosures pursuant to this authorization are allowable only among Care Plus Program participating entities
All numbered items must be completed for authorization to be valid.

42 CFR part 2 prohibits unauthorized disclosure of these records.	
	Initial here to indicate you understand the Participating Entities will share information about your history of drug and/or alcohol use, including any related diagnosis and treatment.
	Initial here to indicate you understand the Participating Entities will share your mental health information.

PART 6: DATE YOUR AUTHORIZATION EXPIRES

Unless otherwise revoked earlier in writing, this authorization expires one year after the date you sign this form.

FOR YOUR REVIEW

I have read the contents of this form presented to me in electronic format. I understand, agree, and authorize the Participating Entities listed on this form to disclose to each other the information described in Part 5 of this form. **I also understand that signing this form is voluntary and that I am not required to sign this form. Treatment, payment, or eligibility for benefits provided by the Participating Entities will not be affected if I do not sign this authorization.** I have the right to revoke this authorization at any time in writing by sending a notice to the Care Plus Program Administrator at careplusprogram@ocgov.com or privacyofficer@ocgov.com. The revocation however will not affect the disclosure of information about me to the Participating Entities have already made in reliance on my authorization. The Participating Entities may re-disclose protected health information (PHI) they access pursuant to this authorization and such re-disclosure may no longer be protected by federal privacy law (e.g. Health Information Portability and Accountability Act of 1996 (HIPAA)). Applicable state or other federal law may require the recipient to obtain your written authorization before re-disclosure unless otherwise permitted or required by such laws. I understand that I will receive a copy of this form. A copy of the original authorization is valid.

PART 7: **SIGNATURE** – INDIVIDUAL OR PERSONAL REPRESENTATIVE	PART 8: DATE
X	

Personal Representative (Print full name)	Personal Relationship to Client / Patient (e.g., guardian, conservator, parent, etc.)		
Personal Representative Street Address	City	State	Zip

THE PARTICIPATING ENTITIES:

- OC Health Care Agency
- OC Social Services Agency
- OC Community Resources
- OC Housing Authority
- OC Probation
- OC Sheriff's Department
- OC Public Defender
- Volunteers of America Los Angeles – Orange County (VOALA)
- People Assisting the Homeless (PATH)
- Friendship Shelter
- Project Kinship

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All numbered items must be completed for authorization to be valid.