

San Luis Obispo County
Multi-Service Referral and Client Release of Information
FAX COVER SHEET

This is not an exclusive list of fax numbers.

- | | |
|--|--|
| <input type="checkbox"/> Allan Hancock EOPS/CalWORKS #922-2606 | <input type="checkbox"/> Prado Day Center fax # 786-0132 |
| <input type="checkbox"/> Cal-SAFE fax # 473-5624 | <input type="checkbox"/> Probation |
| <input type="checkbox"/> Child Care Resource Connection fax # 541-0141 | <input type="checkbox"/> Adult fax # 781-1231 |
| <input type="checkbox"/> Community Link fax # 462-8901 | <input type="checkbox"/> Juvenile fax #781-1169 |
| <input type="checkbox"/> Cuesta College #546-3998 | <input type="checkbox"/> Public Health fax # 781-1372 |
| <input type="checkbox"/> Department of Social Services fax # 781-1701 | <input type="checkbox"/> S.A.F.E. |
| <input type="checkbox"/> Drug and Alcohol Services | <input type="checkbox"/> North fax # 237-3195 |
| <input type="checkbox"/> SLO Central fax # 781-1227 | <input type="checkbox"/> South fax # 474-2025 |
| <input type="checkbox"/> Arroyo Grande fax #473-7188 | <input type="checkbox"/> Central/Coastal fax # 781-1177 |
| <input type="checkbox"/> Atascadero fax #461-6114 | <input type="checkbox"/> School Districts |
| <input type="checkbox"/> Community Action Partnership (EOC) & Parent Education fax #541-1264 | <input type="checkbox"/> San Luis Coastal USD fax #543-6567 |
| <input type="checkbox"/> POPS Program fax #474-2147 | <input type="checkbox"/> Lucia Mar USD fax #473-1587 |
| <input type="checkbox"/> Family Care Network fax # 201-3535 | <input type="checkbox"/> Paso Robles Public Schools fax #237-3476 |
| <input type="checkbox"/> HASLO fax # 595-1372 | <input type="checkbox"/> County Office of Education fax # 541-1105 |
| <input type="checkbox"/> Kinship Center fax # 434-3839 | <input type="checkbox"/> TAPP fax # 595-1346 |
| <input type="checkbox"/> Martha's Place fax # 547-1995 | <input type="checkbox"/> Tobacco Control fax # 781-1235 |
| <input type="checkbox"/> SLO County Mental Health fax # 781-1177 | <input type="checkbox"/> Tri-Counties Regional Center fax # 543-8725 |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Woman's Shelter |
| | <input type="checkbox"/> North County fax # 461-8115 |
| | <input type="checkbox"/> San Luis Obispo fax # 781-6410 |

To: _____

Program/Title: _____

From: _____

Program/Title: _____

Fax: _____

Pages: _____

Phone: _____

Dates: _____

Re: _____

Comments: _____

Federal Reg Title 42: This Information has been disclosed to you from records that are confidential and protected by Federal Law, Federal regulations (42 code of Federal Regs, Part 2) prohibits you from making any further disclosures of the records or information without specific written consent of the person to whom it pertains. A general authorization for the release of Information is not sufficient for this purpose.

NOTE: This message, including all attachments, is intended only for the use of the person(s) to whom it is addressed, and may contain information that is confidential and subject to the attorney-client privilege. It should not be forwarded in printed or electronic form to any other person or computer. If you received this message and are not the intended recipient or an agent responsible for delivering this message to the intended recipient, you have received this message in error; please immediately notify the sender and destroy your copy. Thank you.

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Person Referred: _____		DOB: _____	SSN: _____
Address: _____		Telephone: _____	
Street	City	Zip Code	
Parent/Caretaker (if applicable): _____		Okay to leave message <input type="checkbox"/> Yes <input type="checkbox"/> No	
Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		Contact Person: _____	
If Pregnant: _____	Due Date: _____	Ages of Children: _____	
# Pregnancies: _____	# Live Births: _____	If children ages 0 to 5, was ASQ/ASQ-SE completed: <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, attach copy of score summary sheet</i>	
Referring Person: _____		Phone: _____	Email: _____
Referring Agency: _____		Date of Referral: _____	
Referring To: _____			
Purpose of this Referral: _____			

<input type="checkbox"/> 4 Ps+ Protocol <input type="checkbox"/> ASQ/ASQ-SE Protocol <input type="checkbox"/> VSP Protocol <input type="checkbox"/> SAFE Team Meeting Protocol <input type="checkbox"/> PHN Protocol <input type="checkbox"/> Chronic Neglect <input type="checkbox"/> Young Children 0-5 <input type="checkbox"/> Homeless <input type="checkbox"/> Alcohol & Drug Abuse <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Mental Health <input type="checkbox"/> Poverty <input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Other: _____			

Please have the participant INITIAL for each agency authorized, and line through any agency NOT authorized.

- | | |
|--|--|
| _____ Cal-SAFE (Family School & Community Connection for Pregnant & Parenting Teens) | _____ EOC (Programs: _____) |
| _____ Child Care Resource Connection | _____ Family Care Network |
| _____ County of SLO Department of Social Services | _____ Goodwill / Shoreline (DSS 816) |
| _____ County of SLO Drug and Alcohol Services | _____ Housing Authority of the City of San Luis Obispo |
| _____ County of SLO Office of Education | _____ Kinship Center |
| _____ County of SLO Probation | _____ Martha's Place (Children's Assessment Center) |
| _____ County of SLO Public Health | _____ County of SLO Mental Health |
| _____ County of SLO Tobacco Control | _____ Pediatrician: _____ (Name) |
| _____ Cuesta College | _____ S.A.F.E. or _____ Community Link |
| _____ Other _____ | _____ School District _____ (Name) |
| _____ Other _____ | _____ TAPP Program |
| _____ Other _____ | _____ Tri-Counties Regional Center |

This box for Department of Social Services use only

Office of origination: _____ Case Referral

Case type (Check all that apply): CW CWS S.A.F.E. AS Pre-Adoption Post-Adoption 300 WIC 600 WIC

Purpose of referral: Drug Testing Drug Assessment Kinship Center (Complete DSS 813 then fax to #434-3839) Martha's Place

Mental Health Managed Care (Complete DSS 821 & DSS 823 then fax to Central Access #781-1177)

EOC Direct Services (_____) EOC Parent Ed. Community Resources/In-Home Counseling

Social Worker Supervisor Signature

For Agency Use Below this line: _____

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MULTI-SERVICE CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION WHICH MAY INCLUDE ALCOHOL OR DRUG AND MENTAL HEALTH INFORMATION

I, _____, authorize for myself or for my child, _____, the Multi-Service Team of San Luis Obispo County with the following members that are listed on page 2 **which I have initialed** to communicate with and disclose with one another the following information: (nature and amount to be as limited as possible):

_____ my name and other personal identifying information;
(initial)

_____ my status as a client in treatment;
(initial)

_____ evaluation of my service needs by the Team;
(initial)

_____ participation and attendance of services, with special authorization to include:
(initial)

- Health Services Pregnancy Status
 Mental Health Drug and Alcohol Services

_____ summary of service plans, progress, and discharge plan; and
(initial)

_____ other: _____
(initial)

The purpose of the disclosures authorized in this consent is to: enable the programs and agencies that are authorized to release information to evaluate my need for services and provide and coordinate their services to me.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that records concerning mental health services are protected by State law. I understand a separate authorization would be needed for psychiatric notes and cannot be released herewith.

I understand that I may revoke this authorization to release information any time by giving written notice to the referring agency as noted. I also understand that any information released prior to a revocation of this authorization shall not be a breach of my right of confidentiality. Further, I understand that I have a right to receive a copy of this authorization. This authorization expires one year from date signed.

Dated: _____

Signature of participant

Signature of person signing form if not participant

Describe authority to sign on behalf of participant: _____

parent signing for child