

Authorization for the Sonoma County Multi-Disciplinary Team to Share and Use Information

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Rev. 1/1/25

Client's Legal Name: _____	DOB _____				
Also Known As (Optional Alt Name): _____	Last 4 SSN Digits: <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>				

Sonoma County coordinates teams of health care providers, social service agencies, homeless services, and other agencies to help clients get services they need. By signing this form, you will allow teams from these agencies to share information so they can help you. If you don't sign this form, you can still seek services from these organizations on your own, but you will not be eligible for services from the Sonoma County Multi-Disciplinary Team.

AUTHORIZATION TO DISCLOSE AND EXCHANGE MY HEALTH AND PERSONAL INFORMATION

Initial
Here

INITIAL HERE TO ALLOW ALL AGENCIES LISTED BELOW TO SHARE YOUR INFORMATION:
I've written my initials to acknowledge that the County agencies, health care providers, and other organizations listed below are allowed to share my information with each other.

Sonoma County Departments:

Health Services

Drug & Alcohol Services
Homelessness Services
Mental Health Services
Public Health

Human Services

Adult and Aging including Veterans Services
Economic Assistance
Employment & Training
Family, Youth and Children Services

Other Agencies: (Community Partners)

Community Health Services

Alexander Valley Health Care
Alliance Medical Center
Petaluma Health Center
Santa Rosa Community Health Centers
Sonoma County Indian Health Project
Sonoma Valley Community Health Centers
West County Health Centers

Hospital Systems

Healdsburg District Hospital and clinics
Kaiser Permanente Hospitals and clinics
Providence Health System and clinics
Sonoma Valley Hospital and clinics
Sutter Hospitals and clinics

Other Service Agencies

Community Action Partnership
Face to Face HIV Services
Family Justice Center
Felton Institute
Goodwill Industries
Legal Aid of Sonoma County
North Bay Regional Center
Partnership Health Plan
Siyan Clinical Corp.
Verity
YWCA

Other Sonoma County Departments/Agencies

Child Support Services
Community Development Comm. /Housing Authority
Probation Department
Public Defender's Office
Sonoma County Sheriff's Medical Services

City Based Homeless Services

City of Healdsburg Homelessness Services
City of Petaluma Homeless Services
City of Rohnert Park Homeless Services
City of Santa Rosa Homeless Services
City of Sebastopol Homeless Services
City of Sonoma Homeless Services

Homeless/Housing Service Agencies

Buckelew Programs
Catholic Charities of Santa Rosa
Community Support Network
COTS
HomeFirst Services
Homeless Action Sonoma (HAS)
Interfaith Shelter Network
Interlink Self-Help Center
Nation's Finest – Veteran's Services
Reach for Home
Redwood Gospel Mission
SHARE Sonoma County
Sonoma Applied Village Services
(SAVS) Sonoma Overnight Support
St. Vincent de Paul
The Living Room
West County Community Services

Substance Use Disorder Services

Drug Abuse Alternative Center
Hilltop Recovery Services
Santa Rosa Treatment Program
Women's Recovery Services

Youth Services

TLC Child and Family Services
Voices Sonoma Youth Center

Other: _____	Other: _____
Other: _____	Other: _____

This authorization to release information will **expire 5 years from the date it is signed; or will expire on:** _____ *(Not to exceed 5 Years.)*

HEALTH AND PERSONAL INFORMATION THAT CAN BE SHARED BY THE IDENTIFIED AGENCIES	
THIS AUTHORIZATION ALLOWS DISCLOSURE OF ALL YOUR HEALTH, SOCIAL SERVICES, AND PROBATION RECORDS The agencies listed on this authorization form can share all information from your health care records or personal records. The information may come from your past, present or future physical health provider, mental health provider, or substance use treatment provider. The information may also come from your Social Services records, Justice Records (if any) or the records of any other agency listed on this authorization form. The information the agencies share may be written or spoken.	
Initial Here	Initial here to indicate you understand we will share your mental health information.
Initial Here	Initial here to indicate you understand we will share your Substance Use Program information from past, present and future treating providers.
Initial Here	Initial here to indicate you understand we will share your HIV/Aids information, if any.

PURPOSES AND LIMITATIONS ON THE USE OF YOUR HEALTH AND PERSONAL INFORMATION
The agencies listed on this authorization form will use the information they share to refer you to services or to work with other agencies to provide services that will improve your health and well-being. These services may be in areas like health care, housing, employment, education, nutrition, parenting, child welfare, and/or other traditional social services. This information may also be used for research purposes.

I understand that:	
• I have a right to receive a copy of this authorization and have been offered a copy. • I have the right to tell you to stop sharing my information by writing a letter or email to: Sonoma County Privacy Officer: 1450 Neotomas Ave, Santa Rosa, CA, 95405 or by e-mail at DHS-Privacy&Security@Sonoma-County.org ; or call (707) 565-5703	
If I tell you to stop sharing my information, you will stop on the day I tell you to stop, but it will not affect information you already shared.	
• I understand I don't have to sign this form and my information won't be shared if I don't sign it, however I will not be able to participate with the Multi-Disciplinary Team. If I want to see these services through individual organizations, they won't deny me treatment, enrollment, or eligibility for benefits because I didn't sign this form; however, I won't be served by the IMDT and some services and treatment can't happen if I don't allow my information to be shared. • Information that the agencies share with each other may then be shared by the person who gets the information, except for certain federally protected drug and alcohol records. I understand that some of the information that is shared may no longer be protected by privacy laws; for example, if I allow information to be shared with a family member.	

Employee Name:		Agency of Employee filling out this form:	
Client Signature:	Print Name:		Date:
Representative Signature:		Relation:	Date: