County of Santa Cruz

HEALTH SERVICES AGENCY
Behavioral Health Division
Substance Use Department
1400 Emeline Ave. Building K, Santa Cruz, CA 95060
Phone: (831) 454-7519 Fax: (831) 454-4770

CONSENT FOR SUBSTANCE USE DISORDER TREATMENT

I am requesting services from the Santa Cruz County Substance Use Disorders Services Program (SUDS) system of care at ____.

I hereby acknowledge my consent to enrollment in substance use disorder treatment provided by this agency.

- I understand that substance use disorder treatment may include assessment and treatment planning, individual, family, and group counseling, substance use disorder education, recovery skills training, drug testing, supervised/structured housing, case management. In compliance with the confidentiality regulations described below, coordination with the County SUD, treatment funders, referring agencies, and/or professionals involved in my care including discharge planning, aftercare counseling, and recovery maintenance services.
- I understand that all information and records obtained and maintained in the course of providing treatment services are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- I understand that I may report any dissatisfaction to the Quality Improvement Coordinator, 1400 Emeline Ave., Santa Cruz, CA 95060, and (831) 454-4671. I may also report complaints to the State Department of Health Care Services Substance Use Disorder Compliance Division, P.O. Box 997413, MS# 2601, Sacramento, CA 95899-7413.
- I expressly acknowledge that all the information I have furnished upon intake is true to the best of my knowledge. I have received and read copies of the program rules, participant agreements and client rights, as provided to me by my treatment provider.
- I understand that I may revoke this consent at any time and have a right to receive a copy of this consent.
- I consent to being contacted by the program listed above post discharge for follow-up. ________ (initials)

Copy provided: ☐ Initials______ ☐ Copy was offered but client refused: Initials______

Client Printed Name: ____

Client Signature____ Date___________

Witness/Staff Signature____ Date__________