Appendix B: Blue Shield Consent Form

Blue Shield Transition Pilot

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT/CLIENT		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:	SSN:	DATE OF BIRTH:

THE FOLLOWING ORGANIZATIONS ARE AUTHORIZED TO RELEASE and/or RECEIVE INFORMATON:

☐ UCSD/Gifford Clinic ☐ Council of Community Clinics	☐ Family Health Centers of San Diego ☐ La Maestra Community Health Center ☐ San Diego Family Care

THE FOLLOWING INFORMATION IS TO BE DISCLOSED: (PLEASE CHECK)

☐ Most recent Behavioral Health Assessment or most recent Behavioral Health Update
☐ Psychiatric assessment
☐ Information about medication regime over the last six months, history of keeping appointments, stability over the last six months, current living arrangement and insurance status

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Photocopy or Fax: I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulafons section164.524.

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

SIGNATURE:	DATE:

The above signed authorizes the behavioral health practitioner and the physical health practitioner to release the medical records and Information/updates concerning the patient.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:
If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed, or 60 days after termination of treatment.

VALIDATE IDENTIFICATION

SIGNATURE OF STAFF PERSON:	DATE:

Mid-Shore Mental Health Systems, Inc.

Authorization for Release of Confidential Information

Please fax requested materials to 410-770-4809

Name: _____ **Date of Birth:** _____

Address: _____

Release of Information

I hereby authorize: □ _____ or □ Mid-Shore Mental Health System, Inc.

_____ and

_____ _____

To release health information, including psychiatric and substance abuse records, from the medical records of the above-named person for the following purpose: clarify diagnosis, formulate a treatment plan and aftercare.

Release information to:

□ Mid-Shore Mental Health System, Inc. or □ _____

and _____

_____ _____

For treatment date(s): _____ or □ Any/all previous treatment dates at your facility

Type of information requested:

□ Discharge Summary □ Social Work Summary □ Day Treatment Records □ Lab reports

□ Admission Summary □ Drug Treatment □ Medication History □IEP

□ Psychological testing □ Other_____

This authorization will expire one year from the date signed below unless specific expiration date or condition is named here: _____. The authorization covers only treatment for the dates specified above. I understand that I have the right to refuse to sign this authorization for Release of Confidential Information and authorizing the disclosure is voluntary. I understand I may inspect the information to be used or disclosed, as provided in CFR 186.524.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein described. I understand that this authorization may be withdrawn by me at any time except to the extent that action has been take in reliance upon it. I acknowledge that the material authorized for release may contain, alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. I understand that disclosure of health information to a party other than the one designated above is forbidden without additional authorization on my part. I understand that health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient unless the health information is protected under federal confidentiality rules 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996, 45 CFR pts. 160 and 164. This entity is released and discharged from any liability and the undersigned will hold the facility harmless for complying with this "Authorization for the Release of Confidential Information."

Date_____ Signature_____

Date_____ Witness_____