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 Regulations 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:

DRAFT