Authorization for Behavioral Health and Primary Care Physician to Share Confidential Information

MEMBER CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, _____ (Member Name) give permission to _____ (Behavioral Health Provider) and my Primary Care Physician _____ (Primary Care Physician) to share information about my diagnosis and / or treatment related to substance abuse, mental health, or medical history, NOT including the results of a blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care.

This consent form expires 90 days from the date of signing and I can choose to cancel it at any time.

_____ _____

Member/Guardian/Authorized Representative Date

_____ _____

Witness Date

Member Refusal to Release Confidential Information

I, _____ (Member Name) **DO NOT** give permission to _____ (Behavioral Health Provider) and my Primary Care Physician _____ (Primary Care Physician) to share information about my diagnosis and / or treatment related to substance abuse, mental health, or medical history, including the results of a blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care. I also understand that my refusal to share information does not affect my insurance coverage.

_____ _____

Member/Guardian/Authorized Representative Date

_____ _____

Witness Date

This consent form expires 90 days from the date of signing and I can choose to cancel it at any time.