Blue Shield Shared Treatment Pilot

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I. PATIENT/CLIENT

LAST NAME: Click here to enter text.	FIRST NAME: Click here to enter text.	MIDDLE INITIAL: enter here.
ADDRESS: Click here to enter text.	CITY/STATE: Click here to enter text.	ZIP CODE: enter here.
TELEPHONE NUMBER: enter here.	SSN: Click here to enter text.	DATE OF BIRTH: enter here.

THE FOLLOWING PROGRAMS/ORGANIZATIONS ARE AUTHORIZED TO RELEASE INFORMATON:

☐ Maria Sardiñas Center (Community Research Foundation)	☐ San Ysidro Health Center

THE FOLLOWING PROGRAMS/ORGANIZATIONS ARE AUTHORIZED TO RECEIVE INFORMATON:

☐Maria Sardiñas Center (Community Research Foundation) ☐ Health Quality Partners of Southern California	☐San Ysidro Health Center

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

☐ Current Diagnoses ☐ Active Problem List (primary care) ☐ Current Treatment Goals (AOD)	☐ Current Medications ☐ Lab Results ☐ Ongoing Treatment Strategies

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: I understand I have authorized the disclosure of my health information and California law generally prohibits recipients of my health information from re-disclosing 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.

A. SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

SIGNATURE:	DATE: Click here to enter text.

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.

B. VALIDATION OF IDENTIFICATION

SIGNATURE OF STAFF PERSON:	DATE: enter here.