



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.

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.