FORM TO RELEASE
PROTECTED HEALTH AND PRIVATE INFORMATION

NAME: _____ **DATE OF BIRTH:** _____

ADDRESS: _____

I, _____ and/or _____
(Regional Center Client Name) (Name of Parent/Guardian/Conservator)

allow _____ to share all treatment info related to behavioral
(Name of Regional Center/Regional Center Provider)

health treatment (sometimes called "Applied Behavioral Analysis" or "ABA") originated and maintained by the Regional

Center allowed under federal and State law with _____.
(Name of Medi-Cal Managed Care Health Plan)

I also allow the Medi-Cal Managed Care Health Plan to share this info with the Regional Center. Sharing this info helps my treatment. It also helps my treatment if I move to another Medi-Cal Managed Care Health Plan. Treatment info can include: past care, evaluation/tests, assessments, provider/therapy notes, provider orders, care records, care plan, medicines, and release notes. I know that my record may include info about sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or illness with the Human Immunodeficiency Virus (HIV). It may also include info about behavioral or mental health services. Any alcohol and/or drug treatment records can't be released unless I give written permission. This is due to federal rules (42 C.F.R. Part 2 and 45 C.F. R. pts. 160 & 164). There may be exceptions to this rule. The least amount of information needed should be released for behavioral health treatment.

I will still be allowed to use the plan benefits if I do not sign the form. But, if I do not sign the form, it could take longer to get the care I need. And my plan would not be able to organize all of my care.

I know that sharing the info will help me to not have a break in care, care planning, and/or transfer of care.

This consent form is valid for one (1) year from the date I sign it. I can choose to cancel it at any time.

By signing this form, I:

- allow the use of my protected health and private information shown above for the reasons listed. I know that this form is not required.
- know that I will receive a copy of this form.
- know that I may cancel this agreement at any time. I can send a letter signed by me to the Regional Center where I have been getting my Behavioral Health Treatment service. I can also send a letter to my Medi-Cal Managed Care Health Plan. If I cancel, the agreement will stop on the date the letter is received or the date listed in the letter, whichever is later. It will not affect information that has already been used or revealed.

This agreement is good for one (1) year from when I sign it. Or 60 days after the end of treatment, whichever is later. I can cancel it at any time.

_____ _____
(PRINTED NAME) **(REGIONAL CENTER CLIENT/PARENT/GUARDIAN/CONSERVATOR SIGNATURE)**

_____ _____
(DATE) **(RELATIONSHIPTO PATIENT)**

See the back side of this page for notice to providers on sharing any alcohol and/or drug treatment records.

PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.