

**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.