PATIENT AUTHORIZATION FORM FOR DISCLOSURE OF HEALTH INFORMATION AND/OR BEHAVIORAL HEALTH INFORMATION

PLEASE READ THE ENTIRE FORM, **ALL FIVE PAGES**, BEFORE SIGNING BELOW

Information of person whose health information is being disclosed:

Name (First Middle Last): _____ Date of Birth (mm/dd/yyyy): _____

Address: _____ City: _____ State: _____ Zip: _____

South Florida Behavioral Health Network (SFBHN) has developed a coordinated system of care to provide behavioral health (mental health and substance abuse) treatment services. This care is provided through entities that are part of SFBHN's Network of Providers. To promote quality of care and efficient and coordinated services, as well as to communicate with the Florida Department of Children & Families (DCF) and the Florida Medicaid Program to obtain payment for your care, SFBHN must be able to share certain information about you with members of its Network and others that help SFBHN operate. Please read this form, and let us know whether you give permission for us to share your information for these purposes.

By signing this form, you are voluntarily giving your permission to allow the use and disclosure (including paper, oral, and electronic sharing):

OF WHAT: ALL MY HEALTH INFORMATION, including information about sensitive conditions (if any).

This includes health information created before or after the date I signed this form. Health information includes, but is not limited to, my demographic information (name, address, date of birth, Social Security Number, race/ethnicity), and location of intake, treatment site and case management. It includes all records and other information regarding my health history, treatment, hospitalization, tests, residential and outpatient care, including medical history, physical exams and test results. This also includes my specific permission to release any and all of the following information:

a. Drug, alcohol, or substance abuse;
b. Psychological, psychiatric or other mental impairment(s), mental condition or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501);
c. Sickle cell anemia;
d. Birth control and family planning;
e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis;
f. Genetic (inherited) diseases or tests.

Additionally, Medicaid eligibility information may be shared with SFBHN.

FROM WHOM: **All information sources.**

This includes, but is not limited to, medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and Veterans Affairs health care facilities, state registries and other state programs, social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, the Florida Department of Children and Families, state Medicaid, Medicare and any other governmental program.

TO WHOM: (**please check one**)

NOTE: Your basic demographic information (name, address, year of birth, and last four digits of social security number) may still be shared with network providers, SFBHN and its business associates, service providers, and payors listed in Attachment I to facilitate SFBHN operations. It will also be visible in the consumer search screen.

☐ **SFBHN its payors, trusted business associates, and service providers and ALL participating Network Providers of South Florida Behavioral Health Network listed in Attachment I.**

☐ **ONLY SFBHN and my current SFBHN treating Provider.**

Current Treating Provider Name: _____ Phone: (_____)

Address: _____ Fax: (_____)

☐ **SFBHN, my current SFBHN treating Provider, AND the specific organization(s) permitted to receive my information as listed below.**

Current Treating Provider Name:_____ Phone: (_____)

Address:_____ Fax: (_____)

Person/Organization Name:_____ Phone: (_____)

Address:_____ Fax: (_____)

Person/Organization Name:_____ Phone: (_____)

Address:_____ Fax: (_____)

Person/Organization Name:_____ Phone: (_____)

Address:_____ Fax: (_____)

Please use the back of the form to identify additional providers.

PURPOSE: To allow access to your information as needed for the following (see page 4 of this form for more information):

- To provide you with medical treatment
- To obtain payment for your care
- For health care operations purposes, including disclosures to business associates
- To provide you with treatment-related services and products
- To make it easier to coordinate your care and schedule follow up services
- To evaluate and improve patient safety and the quality of medical care provided to all patients
- To create de-identified information to be used for any lawful purpose
- To create limited data sets to be used for research, public health, or health care operations
- To create aggregated data reports for group statistical research and analysis. The research and analysis will not contain any information that could be used to contact or identify you

Note: If you have not allowed full access to your information:

1. You may not be able to receive certain care coordination services, which require the sharing of your information; and
2. Your demographic information will still be shared with SFBHN and its business associates, service providers and payors. Your basic demographic information will also be visible in the consumer search screen.

EFFECTIVE PERIOD: **This authorization/permission form will remain in effect until the day you withdraw your permission, the date of your death, or one year from the date signed below, whichever is sooner.**

REVOKING YOUR PERMISSION: Your consent can be revoked at any time except to the extent that the organization which is to make the disclosure, has already taken action in reliance on it. You can revoke your permission at any time by giving written notice to the person or organization to which you originally gave this form.

EFFECT OF REVOCATION OR EXPIRATION: Even if your consent expires or is withdrawn, you will still be able to receive services from SFBHN. Revocation or expiration of your permission will not affect actions taken while your permission was in effect. If your information can no longer be shared, it will affect your ability to take full advantage of care coordination services provided by SFBHN.

PHOTOGRAPHIC CONSENT AND RELEASE:

You acknowledge that you have been advised that a photograph will be taken of you for the purpose of assisting in your care, documenting your treatment for payment reasons, and assisting in health care operations.

Please initial one of the following:

_____I consent to have my photograph taken and shared with South Florida Behavioral Health Network, its Network Providers, and its trusted business associates and service providers. I authorize the release of my image for the purposes explained in this form. I understand that my most recent photograph will be shared in the SFBHN system.

_____ I do not consent to have my photograph taken.

AGREEMENT:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be disclosed to other parties, like SFBHN's business associates, service providers and payors , and other network providers (see page 4 for details).
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read all pages of this form and agree to the disclosures specified above from the sources listed**.

X _____ _____

Signature of Patient Date Signed (mm/dd/yyyy)

X _____ _____

Signature of Patient's Legal Representative (if applicable) Date Signed (mm/dd/yyyy)

_____

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- ☐ Parent of minor
- ☐ Legal Guardian
- ☐ Other personal representative (explain: _____)

This form shall be valid for 12 months unless revoked as indicated in the "Effective Period" section above.
You are entitled to get a copy of this form.

Explanation of "Patient Authorization Form for Disclosure of Health Information"

PLEASE READ AND INITIAL THIS PAGE BELOW

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions.

Why Your Information is Used and Disclosed: The South Florida Behavioral Health Network (SFBHN) works with the Florida Department of Children and Families to administer and manage a coordinated system of care for adults and children. The SFBHN Providers need to exchange information with each other to better manage your care. Trusted business associates and service providers of SFBHN are working to develop ways to better coordinate care and to improve quality and outcomes. As part of its efforts, these trusted business associates and service providers have developed utilization management software that is used by SFBHN and the Providers in its network. The business associates and service providers use and analyze de-identified information from that system for statistical research and analysis. Anything that identifies you will be removed from the information. This de-identified information will also be used by the trusted business associates and service providers to develop new commercial products.

Definitions: In this form, the term "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR §§ 160.103 and 164.501).

"To Whom":

- If you specified a healthcare provider in the "TO WHOM" section above, this permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates, subcontractors or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified.
- If you specified an organization other than a healthcare provider in the "TO WHOM" section above, this permission would also include that organization's staff or agents, business associates and subcontractors who carry out activities and purpose(s) permitted by this form for that organization that you specified.

Revocation: You have the right to revoke this authorization and withdraw your permission at any time regarding future uses by giving written notice. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

Re-disclosure of Information: Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources.

_____
Initials

Attachment I

South Florida Behavioral Health Network Providers

Banyan Health Systems, Inc.
Behavioral Science Research Institute, Inc.
Better Way of Miami, Inc.
Camillus House, Inc.
Catholic Charities of The Archdiocese of Miami, Inc.
Citrus Health Network, Inc.
Community AIDS Resource, Inc. (d.b.a.) CARE Resource
Community Health of South Florida Inc. (CHI)
Concept Health Systems, Inc.
Douglas Gardens Community Mental Health Center of Miami Beach, Inc.
Family & Children Faith Coalition, Inc. d/b/a Hope for Miami
Federation of Families/ Miami-Dade Chapter, Inc.
Fresh Start of Miami-Dade, Inc.
Gang Alternative, Inc.
Guidance Care Center, Inc. (GCC)
Here's Help, Inc.
Institute for Child and Family Health, Inc. (ICFH)
Jessie Trice Community Health Center, Inc.
Key West HMA LLC (d.b.a.) Lower Keys Medical Center
King David Foundation, Inc./CLAPA
MDC-Community Action and Human Services Dept. (MDC-CAHSD)
Miami-Dade County Juvenile Services Department (MD-JSD)
Miami-Dade Homeless Trust (MDHT)
Monroe County Coalition, Inc.
New Hope CORPS, Inc.
New Hope Drop-In Center, Inc.
New Horizons Community Mental Health Center, Inc.
Passageway Residence of Dade County, Inc.
Psychosocial Rehabilitation Center, Inc., d.b.a, Fellowship House
Public Health Trust of Miami-Dade County, Florida (PHT)
South Florida Jail Ministries, Inc. (d.b.a.) Agape Family Ministries
Switchboard of Miami, Inc.
The Center for Family and Child Enrichment, Inc. (CFCE)
The Key Clubhouse of South Florida, Inc.
The Miami Coalition For a Safe and Drug-Free Community, Inc.
The Village South, Inc.

NOTE: SFBHN's business associates include, but may not be limited to, IBM Global Business Services and Otsuka America Pharmaceutical, Inc. SFBHN also has service providers, such as FireHost and CapGemini. SFBHN's payors include Florida Department of Children and Families and the Florida Medicaid Program.