KAISER PERMANENTE®

BEHAVIORAL HEALTH COORDINATED CARE OPT OUT FORM

You have the right to opt out from sharing your behavioral health information that will occur from behavioral health visits, messages and/or communications between you and your behavioral health provider(s) and/or behavioral health clinical staff after August 1, 2016 with your health care team. We recommend that you think about not opting out, because that can limit your health care team from being able to manage your care in a timely and safe way. Please note that we may need to share your behavioral health information without your approval as permitted by law (i.e., emergency care).

I have received and reviewed the Behavioral Health Coordinated Care Privacy Notice. I understand that opting out may affect the coordination of my care and services with my other health care providers.

I want to opt out from sharing my behavioral health information that will occur from behavioral health visits, messages and/or communications after August 1, 2016 with my other health care providers.

Signature _____

Parent/legal guardian signature (for KP members under 18 years of age)

_____

_____

If parent/legal guardian, relationship to minor

Date _____

Medical Record Number: _____

A copy of this signed form will be kept on file in the patient's electronic medical record.