City and County of San Francisco
Department of Public Health
BEHAVIORAL HEALTH SERVICES

Name: _____
Last, **First**

Date of Birth: _____

BIS #(if known): _____

Care Quality Network Information Exchange - Opt Out/Rescind Out Out Form

This form is to be used to indicate that you do not wish to participate in the secure electronic sharing of information between Behavioral Health Services and other treatment providers involved in your care. You can also use this form to rescind a previous decision to opt out. Please read the following information carefully before submitting this form.

What is Care Quality Network Information Exchange? The Care Quality Network is a secure way of sharing your health information electronically with authorized doctor's offices, hospitals, labs, and other health care providers.

What is the benefit of sharing information? The benefit of allowing electronic information sharing is to ensure that providers involved in your care have the most updated and comprehensive information when coordinating and making decisions with you about your care.

What information is included? Behavioral Health information may include, but is not limited to: care team members, medications, allergies, current and past lab results and dates of encounters.

What information is not included? The contents of notes and assessments written by your BHS treatment providers or information that requires your specific authorization to release under federal law including Substance Use Disorder Treatment.

Who can see my records? Only health care providers who are involved in your treatment who have specific access to the Care Quality Network will be able to view your records.

Are there risks to opting out? Yes. The goal of the information sharing is to allow your providers to more quickly share your behavioral health and physical health information. By opting out of this exchange of information, your providers will have less information about you when making decisions about your healthcare with you.

I don't want to Participate. How do I Opt out? Your health information will be visible to your service providers unless you complete and fax this form to DPH BHS HIM at (628) 206-7517. Please allow five (5) business days for us to process that request. Your choice to opt-out will not affect your ability to access care. You can change your mind about participating or not at any time.

☐ Opt-Out: I do not want my Behavioral Health information to be shared electronically with other treatment providers.

☐ Cancel Opt-Out: I cancel my previous decision to opt-out. I allow my Behavioral Health information to be accessible to my other treatment providers.

Signature: _____ Date: _____
client/parent/conservator/other legal representative

Relationship if other than the client: _____

Note: Federal and state regulations allow your behavioral health and physical health information to be shared verbally and in writing between providers giving you care. For more information about how your healthcare information is shared and your rights, see the "Notice of Privacy Practices." You signed a receipt of this Notice on the first day that you received services at DPH. You can ask your provider for a copy.