NAPA COUNTY
Health & Human Services Agency

HHSA Mental Health Division
2751 Napa Valley Corporate Drive
Napa, CA 94558
707-259-8151

MEDI-CAL BENEFICIARY REQUEST TO CHANGE PROVIDER

Date: _____

Name and Contact Information of Medi-Cal Beneficiary:

Last Name: _____ First Name: _____ Phone: _____

Street Address: _____ City: _____ Zip Code: _____

Signature of Beneficiary: _____ Date: _____

Email: _____ May we contact you via email? ☐ Yes ☐ No

☐ I am submitting this Request to Change Provider form on my own behalf

☐ I wish to have someone else assist me with my Request to Change Provider. *Please complete the Authorization for Release of Information attached to this form.*

☐ I request that I be assigned a different service provider.

My current provider is: _____

The reason I am requesting a change of provider is:

☐ I request a provider who specializes in my ☐Ethnicity ☐Language ☐Sexual Orientation ☐ Gender ☐Age

☐ Other: _____

☐ I have discussed my concern with my current provider.

☐ I have NOT discussed my concerns with my current provider.

☐ **Request APPROVED by**: (Supervisor/Designee Name/Date)_____

☐ Please call _____ to arrange for your next appointment <OR>

☐ Your appointment has been schedule for Date: _____ Time: _____
with new provider: _____

☐ **Request DENIED by:** (Supervisor/Designee Name/Date) _____
Reason(s): _____

☐ I provided notification of the denial and informed the beneficiary of their grievance rights on: _____ (date of notification).

_____
(Signature of person providing grievance information)

Staff Routing Instructions

Person taking request: Complete the top half and provide one copy of the entire form to MH Director and one copy to Supervisor of the service on the day of request.

Supervisor Reviewing: Complete bottom half and provide one copy of entire form to MH Director within 30 days of beneficiary request.

AUTHORIZATION TO RELEASE INFORMATION

Completion of this document authorizes the use and disclosure of your confidential health, financial, and personal information consistent with State and Federal law pertaining to the privacy of such information. Coordinating care, treatment and services will promote physical and mental health, safety, recovery and overall well-being that leads to a higher standard of care. **Review and complete all sections below for a valid authorization.**

1. Client Information:

First Name: _____ Last Name: _____

Date of Birth:_____Phone #: _____

Address: _____

USE AND DISCLOSURE

2. Purpose of Authorization (check all that apply):

- ☐ Evaluation
- ☐ Treatment Planning
- ☐ Coordination of Care or Services
- ☐ Legal
- ☐ Financial
- ☐ At the request of the individual
- ☐ Other (specify):_____

3. Description of Information To Be Disclosed or Exchanged– may be written or verbal (check all that apply):

- ☐ Complete Record
- ☐ Diagnosis
- ☐ Psychiatric Evaluation
- ☐ Assessments
- ☐ Social History
- ☐ Progress Notes
- ☐ Psychological or Vocational Testing
- ☐ Laboratory Results
- ☐ Discharge Summary or Aftercare Plan
- ☐ Probation or Correctional Proceedings
- ☐ Benefit or Eligibility Details
- ☐ Billing or Financial Records
- ☐ Verification of Services
- ☐ Other (specify) _____

Date Range of Records to be Disclosed (if applicable):_____to _____

To limit any information marked above, specify here: _____

4. This Information Requires Special Protection

Initial to allow use and disclosure (if applicable):

Mental Health Records	*Initial Here*	Substance Use Disorder Records	*Initial Here*	HIV/AIDS Test Results	*Initial Here*	Genetic Testing	*Initial Here*	Sickle Cell Anemia	*Initial Here*

5. Recipients

(a) Initial two or more to facilitate the exchange of information between Programs (if applicable):

Initial Here	Napa County HHSA - Alcohol and Drug Services	*Initial Here*	Napa County HHSA - Public Health
Initial Here	Napa County HHSA - Child Welfare Services	*Initial Here*	Napa County HHSA - Self-Sufficiency Services
Initial Here	Napa County HHSA - Comprehensive Services for Older Adults	*Initial Here*	Other (specify): _____
Initial Here	Napa County Housing and Homeless Services Division	*Initial Here*	Other (specify): _____
Initial Here	Napa County HHSA - Mental Health	*Initial Here*	Other (specify): _____
Initial Here	Napa County Probation	*Initial Here*	Other (specify): _____

OR

(b) Specific person or organization to which disclosure is to be made (if applicable):

Name:	☐ **One-way** ⇒	Name:
Address:		Address:
City:	☐ **Two-way** ⇔	City:
State: Zip Code:		State: Zip Code:
Phone: Fax:		Phone: Fax:

6. Expiration

Enter the **date** this authorization will expire: _____

NOTICE OF YOUR RIGHTS

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits.
  Program name (optional): _____
- I may revoke or cancel this authorization at any time. My revocation will be effective upon receipt but will have no impact on uses or disclosures made while the authorization was valid. My revocation may be verbal or in writing, signed by me or my personal representative.
- I have a right to receive a copy of this authorization.
- I understand information disclosed pursuant to this authorization could be re-disclosed by the recipient, and unless prohibited by State or Federal laws, may no longer be protected.
- I may inspect or obtain a copy of the health information to which this authorization applies.
- I may request and receive clarification of any concerns or questions I may have regarding this authorization.

SIGNATURE

7. Required Signatures

Client or Personal Representative:_____Date: _____

Personal Representative[1] printed name: _____

☐ If checked, this authorization is not to exceed 12 months.

Internal Use Only

Program Contact printed name:_____Phone number: _____

[1] Personal Representative is the person who has legal authority to make decisions on behalf of the client.