Practitioner Credentialing Authorization to Disclose Information

General Information Regarding This Authorization:
In order for the Behavioral Health Provider Network to access and verify my educational background, professional qualifications and suitability to provide autism services, I hereby authorize the disclosure of my Protected Health Information ("PHI") and other confidential information to credential me as a qualified autism service practitioner under California Health & Safety Code 1374.73 and the requirements of theBHPN.

Request for Disclosure of Information regarding:
First Name: _____ Last Name: _____
Middle Name: _____ Date of Birth: _____

Commented [SF1]: Practitioner Information goes here

Person/Organization Is Authorized To Disclose My Information:
Name: _____
Address: _____ Phone: _____
City, State, Zip: _____ Fax#: _____

Commented [SF2]: Insert Provider Information Here

To Person/Organization:
The following persons may access my information: the Behavioral Health Provider Network (theBHPN), Kaiser Permanente, their vendors, and any subsequent employers within the BHPN.
Address: 2820 Shadelands Drive, Suite 200 Phone: 855-843-2476
City, State, Zip: Walnut Creek, CA 94598

Description of the Information to be Disclosed:
☒ Health Screening Report (Physical Capability Report)
☒ Immunizations/Immunity Records

Purpose of Disclosure:
☒ BHPN Credentialing & Oversight

Length of Time:
☒ Ongoing

Expiration: This authorization will expire three years after I cease employment with any member of the Behavioral Health Provider Network.

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My Rights:

- I consent to and authorize the use and/or disclosure of the information for the purposes listed above.
- I am signing this authorization freely and voluntarily. I may refuse to sign this authorization. I understand that such refusal will prevent me from treating BHPN clients.
- I may inspect or obtain a copy of the information that is the subject of this authorization. I also have a right to receive a copy of this authorization.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: TheBHPN, 2820 Shadelands Drive, Suite 200, Walnut Creek, CA 94598. Any revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I hereby authorize the BHPN to redisclose information pursuant to this authorization. California law prohibits Recipient from making further disclosure of information unless another authorization for such disclosure is obtained or unless such disclosure is specifically required or permitted by law.

By signing this Authorization, I certify that I have the legal authority to do so.

Name: _____

Signature:_____ Date: _____

Commented [SF3]: Employee must sign