



County of San Bernardino
Department of Behavioral Health

ACTION APPEAL FORM

FORM TO BE COMPLETED BY CLIENT AND FORWARDED TO THE ACCESS UNIT

268 W. Hospitality Lane, Suite 400, San Bernardino, CA 92415-0026
909-381-2420 ♦ 888-743-1478 ♦ TDD 888-743-1481 ♦ Fax 909-421-9272

Client Name: _____ Date: _____ Time: _____

Date of Birth: _____ Gender: M F Preferred Language: _____

Home Address: _____ SSN: _____

City: _____ Zip: _____ Phone: _____

Using Authorized Representative: No Yes if yes, Name: _____
Phone: _____

Clinic or Provider: _____

Did you receive a Notice of Action? Yes No

Did you receive an action as defined as one of the following?

1. Denies or limits authorization of a requested service, including the type or level of service;
2. Reduces, suspends, or terminates a previously authorized service;
3. Denies, in whole or in part, payment for a service;
4. Fails to provide services in a timely manner, as determined by the Department of Behavioral Health or;
5. Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.

If yes, how would you like the Access Unit to review the Action?

Client's Signature: _____ Date: _____



County of San Bernardino Department of Behavioral Health
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

MY RIGHTS

- I may refuse to sign this Authorization. It will not affect my ability to get treatment.
- I have a right to receive a copy of this Authorization.
- To the extent permitted by law, I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but must do so in writing and submit it to the following address: _____

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

Information released by this Authorization could be re-released by whoever receives it, and the re-release is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

SIGNATURE

Date: _____

Time: _____ am pm

Signature: _____
(patient/representative/spouse/financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient:

Witness: _____
