

AUTHORIZATION TO SHARE CONFIDENTIAL MEMBER INFORMATION (ASCFI) REVOCATION FORM

First Name

Middle Name

Last Name

Date of Birth

Medi-Cal Client Index Number (as applicable)

Use this Form if you want to take back your consent for Care Partners to share certain types of your information.

The ASCMI Revocation Form should only be used if you have previously signed the ASCMI Form (either AB 133 or Non-AB 133) consenting to sharing your information.

Client Information

Client Name: _____ Date of Birth (mm/dd/yyyy): _____

Medi-Cal Client Index Number (as applicable)¹: _____

Mailing Address: _____

City: _____ State: _____ Zip Code²: _____

Residential Address: _____

City: _____ State: _____ Zip Code (optional): _____

Phone Number (optional): _____ E-mail Address (optional): _____

¹ The Client Index Number is the first nine characters of the identification number located on the front of the Medi-Cal Member's Benefits Identification Card.

² This can be any address where you can receive mail, including the address of a friend, shelter, or family member.

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By completing the ASCMI Revocation Form, any data that you selected “**Yes**” to sharing in the ASCMI Form will be changed to “**No / Does not apply to me.**” This may include any of the following types of information listed below. If you are interested in changing only some of your consent preferences, complete a new ASCMI Form.

ASCFI Form (AB 133 and Non-AB 133)

- » Substance use disorder information that is protected by 42 C.F.R. Part 2.
- » Housing information, including your housing status, history, and supports.

ASCFI Form (Non-AB 133 only)

- » Some mental health information.
- » Intellectual and developmental disability information.
- » HIV test results.
- » Genetic test results.

Client Name	Client Signature	Date (mm/dd/yyyy)
Parent/Guardian/Legal Representative Name	Parent/Guardian/Legal Representative Signature	Date (mm/dd/yyyy)