Authorization for Use or Disclosure of Medical Information

Read this information first

You should complete this form if you wish to authorize ValueOptions to use or disclose your medical information to persons who may or may not directly be involved in making decisions regarding your health care. This authorization will remain in effect until the (a) date you specify; (b) one (1) year from date signed; or (c) the date you withdraw your permission; whichever date occurs sooner.

*****Mail this form to:**

Step 1: Complete the demographic information for the person receiving services:

1. ________________ **Name**
2. ___/___/_____ **Date of Birth**
3. ________________ **Address**
4. (___)___-____ **Home Phone Number**
5. ________________ **Name of Member**
6. ________________ **Member ID #**

Step 2: Tell us what medical information may be used or disclosed:

7. Check the appropriate box to indicate what information may be used or disclosed:
   a. My entire record ☐
   b. Other (see instructions) ☐ ________________
8. Check the appropriate box to indicate the purpose of the use or disclosure:
   a. At my request ☐
   b. Other (see instructions) ☐ ________________

Step 3: Tell us who you are authorizing to use or receive your medical information

9. ________________ Name of Authorized person
10. ________________ Address of Authorized person
11. **OPTIONAL:** authorization termination date: ___/___/_____

Step 4: **Complete and sign this authorization for alcohol and/or drug abuse records:**

I acknowledge that information to be used or disclosed as a result of this Authorization may include records that are protected by other federal and/or state laws applicable to substance abuse. **I SPECIFICALLY AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION RELATING TO DRUG AND/OR ALCOHOL ABUSE.** The recipient of drug and/or alcohol abuse information disclosed as a result of this Authorization will need my further written authorization to re-disclose this information. 42 CFR §2.32 restricts any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

12. ______________________________ ___ ___/___ ___/___ ___ ___ ___

Person receiving services or Personal Representative's signature** — Month Day Year

13. ______________________________ ___ ___/___ ___/___ ___ ___ ___

Parent/Guardian Signature (if required by State Law) — Month Day Year

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Step 5: Complete your acknowledgement that you understand that:

- You have the right to review the information that is being used or disclosed;
- You do not have to complete this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits;
- The information used or disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws;
- You have a right to revoke this authorization at any time**, except to the extent that ValueOptions has already acted in reliance on it,** by completing and sending to ValueOptions a "Revocation of Authorization" Form, which may be obtained from ValueOptions;
- You have a right to receive a copy of this signed authorization; and
- A statutory privilege for confidential communications between a patient and a licensed psychologist exists. (For New Jersey residents only)

14. ______________________________ ______________

Person receiving services or Personal Representative's signature** — Date

15. ______________________________ ______________

Personal Representative's relationship ** — Date

*** Attach a copy of the appropriate legal document granting authority*