Authorization for Beacon Health Options to Release Confidential Information

Important: By completing all sections of this form you allow Beacon Health Options, Inc. (Beacon) to disclose health care information to the individuals you identify for up to one year. You may allow Beacon to share health care information with your family, providers, legal representative, or **anyone** you wish to have access. Please fill in all sections as incomplete forms may be returned.

Please note: It is also important for your doctor to have access to your medical information to ensure you receive the best care possible, including any follow-up care that may be needed. To allow Beacon the ability to send your health care information to your doctor, complete and sign this form. We will only send information that pertains to your care.

If your request involves alcohol or substance use information, please pay attention to the special instructions in the applicable sections.

SECTION 1: WHOSE HEALTH CARE INFORMATION IS TO BE RELEASED?

I**,** _____ **(Member Name)** authorize Beacon (or any Beacon Health Options subsidiary holding my information) to disclose my health care information as described below.

Additional Member Identifying Information Member ID#: _____ DOB: ____/____/____

Phone Number: _____ Name of Health Plan: _____

SECTION 2: WHO IS TO RECEIVE THIS HEALTH CARE INFORMATION?

Print the Name(s) of person, provider or entity who will be receiving your information and contact information (if known):

_____

_____

_____

Phone number of who will be receiving your information: _____

Is it ok to include information from past, present, and/or future treating provider(s)?: ☐Yes ☐No

SECTION 3: WHY SHOULD THIS HEALTH CARE INFORMATION BE RELEASED?

Reason ("At my request" is an acceptable response): _____

_____

Specify, if possible: ☐Care Coordination/Management ☐Claim Assistance ☐Quality of Care Review

☐Other (Please explain reason): _____

SECTION 4: WHAT HEALTH CARE INFORMATION MAY BE RELEASED?

BY INITIALING the items on the following page, you authorize Beacon to release specific types of information to the party identified in Section 2 above:

____ Mental health information and/or records **(INITIALS REQUIRED)**

____ Alcohol or substance use information and/or records **(INITIALS REQUIRED)**

Optional: ☐ Claims info ☐ Authorizations ☐ Explanation of benefit letters ☐ Denials/Appeals info ☐ Clinical notes

____ HIV/AIDS related information and/or records **(INITIALS REQUIRED)**

____ Other health information, please specify **(INITIALS REQUIRED)**: _____

Special instructions, if any (you may specify provider, date span, service type, etc.): _____

_____

SECTION 5: HOW LONG SHOULD THIS AUTHORIZATION LAST?

This authorization shall be in force and effect **for one year** or until I revoke it, in the manner described below or until **(insert expiration date or event**) _____ *(whichever is shorter)*.

SECTION 6: WHAT ARE MY RIGHTS?

- You have a right to request a copy of this form and to request a copy of the information that is being disclosed.
- You do not have to sign this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits.
- The information disclosed by this authorization may be at risk for re-disclosure by the recipient and if that happens, it might no longer be protected by federal privacy laws.
- You have a right to revoke this authorization at any time. ***But if you revoke this authorization, the revocation will not affect the disclosure of any information that Beacon has already sent to the recipient***.
- If you authorized release of alcohol or substance use information to a healthcare organization that is not your treating provider, for the next two years, you have the right to find out who within that organization actually saw your information. You should contact the organization directly for that information.

Please note that if you have authorized the release of ONLY alcohol or substance use treatment records, you may revoke this authorization verbally. Revocation involving all other types of health care records must be in writing.

_____ _____

Signature of the Member or the Member's Legally Authorized Representative* Date

_____

Print Name

**** NOTE: If you are signing as the individual's Legally Authorized Representative, attach a copy of the appropriate legal document(s) granting you the authority to do so. Examples would be a health care power of attorney, a court order, guardianship papers, etc.*** **A financial or business power of attorney is NOT sufficient.**

Please contact the phone number for behavioral health, mental health, or substance use services on your medical ID card with any questions or to determine where to mail or fax your request.