AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Individual/Member Name: _____
Member Identification Number: _____
Member Date of Birth: ___ ___/ ___ ___/ ___ ___ ___ ___

I, the undersigned, authorize **ValueOptions**® to release all my individually identifiable health information in their possession to the Maryland **Department of Rehabilitative Services (DORS)** for the purposes of initiating and obtaining the services provided by DORS and to coordinate care. I expressly request that ValueOptions release:

- all mental health related service authorization correspondence
- all mental health related medical necessity determinations, and
- the medical/clinical information collected from other treating providers in order to make such medical necessity determinations

This authorization permits **ValueOptions** to disclose individually identifiable health information about me both prior to and subsequent to the date of my signature until such time I am no longer eligible for or receiving services from DORS. I understand that signing this document is voluntary and that the authorization to release my information may be revoked at any time.

I understand the information to be released or disclosed may include information, if any, relating to acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. This release permits re-disclosure of this type of information and I explicitly authorize the release or disclosure of this type of information.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restriction of which have been specifically considered and expressly waived.

I Understand and Agree to the following: (45 CFR § 164.508(c)(2)(i-iii))

- I have the right to review the information that is being disclosed;
- I do not have to complete this authorization and my refusal will not affect my benefits unless this authorization is necessary to determine my benefits;
  I am refusing to sign: ☐YES Initials: _____
- The information disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws except to the extent where the information is protected from further redisclosure under federal alcohol and substance abuse law;
- I have a right to revoke this authorization at any time by sending written notice to ValueOptions®. Revoking this authorization will not have any effect on actions that ValueOptions® took in reliance on the authorization prior to receiving notification. For your convenience, a "Revocation of Authorization" Form may be obtained from ValueOptions® **at 1-800-888-1965**
- ValueOptions® will not receive compensation from a third party for using or disclosing this information, and

- I have the right to a copy of this form after I sign it.
  I would like a copy of this form: ☐ YES Initials: _____

Signature of the Individual or the Individual's Legally Authorized Representative**++ Date
(45 CFR § 164.508(c)(1)(vi))

Print Name:

Relationship to the Individual/Member: (45 CFR § 164.508(c)(1)(iv))

☐ Self ☐ Legally Authorized Representative**

☐ Parent of Minor Child (*Power of Attorney, Legal Guardian, Executor or Administrator*)

***If you are signing as a Legally Authorized Representative attach a copy of the appropriate legal document(s) granting you the authority to do so. You do not have to attach copies of documents if you already have those documents on file with ValueOptions®. My legal documents granting authority to act on the individual's behalf are already on file with ValueOptions®:* ☐ YES Initials: _____

++A minor must always sign the authorization form in order to release alcohol and substance abuse information.

The following notice will accompany all substance abuse related hard copy documents released under this authorization:

NOTICE PROHIBITING ANY FURTHER REDISCLOSURE OF ALCOHOL OR DRUG TREATMENT INFORMATION

Prohibition on Redisclosure of Confidential Information

This notice accompanies a disclosure of information concerning a member in alcohol/drug treatment, made to you with the consent of such member. This information has been disclosed to you from records protected by federal confidentiality rules, 42 Code of Federal Regulations (CFR) Part 2. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of health information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Attach this form to the inquiry requesting Supported Employment authorization in Provider Connect. This form may be faxed to ValueOptions at 1-877-502-1037 if you are unable to attach to the inquiry.