Authorization to Disclose Health Information

By completing this form, you allow Beacon Health Options to disclose health care information to the individuals you identify.

SECTION 1: IDENTIFY THE PERSON WHOSE INFORMATION IS TO BE RELEASED

Name _____

Member ID# _____

DOB___/___/____ Phone Number _____

SECTION 2: IDENTIFY THE PERSON OR ENTITY WHO IS TO RECEIVE THE INFORMATION AND THE REASON FOR THE DISCLOSURE (THE REASON FOR DISCLOSURE MAY BE "AT MY REQUEST")

Print the Name(s) of person receiving records, contact information, and reason for disclosure:

_____

_____

_____

_____

Phone Number of Person Receiving Records:_____

Reason: _____

_____

SECTION 3: IDENTIFY WHAT HEALTH INFORMATION MAY BE RELEASED

BY INITIALING the following items, you are authorizing Beacon to release the following specific types of information to the person(s) identified in Section 2 above:

____ Mental health information and/or records

____ Alcohol or substance use information and/or records

____ HIV/AIDS related information and/or records

____ Other health information: _____

Limitations, if any (you may limit by provider, date span, service type, etc.)

_____

_____

SECTION 4: IDENTIFY HOW LONG YOU WOULD LIKE THIS AUTHORIZATION TO LAST

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

SECTION 5: YOUR 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 no longer protected by federal privacy laws.
- You have a right to revoke this authorization at any time. Revoking this authorization will not have any effect on actions that Beacon takes prior to receiving the notice of revocation.

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

_____

Signature of the Individual or the Individual's Legally Authorized Representative*

_____

Print Name

_____

Date

**** NOTE: If you are signing as the member'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.***

> Please contact the Beacon number on your medical ID card to determine where to mail or fax your request.