U.S. Behavioral Health Plan, California

OPTUMHealth™
Behavioral Solutions of California

Authorization for Release of Information

_____ _____
Member/Patient's Name Birth Date

_____
Member/Patient's ID#, SSN, or Chart # (Circle One)

_____
Street Address City State Zip

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

I also understand that my health plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this authorization at any time by notifying USBHPC in writing, but if I do, it will not have any effect on any actions USBHPC took before it received the revocation.

I hereby authorize USBHPC to (check all that apply):

☐ Exchange with ☐ Release to ☐ Obtain from **the parties I have indicated below**

I hereby authorize USBHPC to exchange / release / obtain information:

☐ verbally only ☐ in written form only ☐ both verbally and in writing

Person/organization receiving/communicating the information:

Name: _____

Address: _____

_____

Phone Number: (_____)_____

Description of individually identifiable health information (check appropriate type(s) of information) to be released/exchanged/obtained:

☐ All
☐ Claims
☐ Eligibility/Benefits
☐ Clinical records used to make benefit determinations (may include HIV/AIDS and/or Substance Abuse information)
☐ All records relating to a Disability claim
☐ All pertinent documentation USBHPC deems appropriate for the purpose(s) checked below
☐ Other (describe):

☐ Treatment Plan(s)
☐ Outpatient Progress Reports
☐ Attendance Only

_____

The purpose of this release is (check all that apply):

☐ To allow the clinically appropriate management and coordination of the Member/Patient's mental health and/or substance abuse treatment and/or coverage under the Member/Patient's health benefit plan (Care Management and Coordination).

☐ Benefit Management

☐ Claims Administration/Payment

☐ Employer Mandated Treatment Referral

☐ Administration of a Worker's Compensation claim

☐ Administration of a Disability claim

☐ Subpoena or other legal process

☐ To release physical records described above

☐ Other (describe):

THE MEMBER/PATIENT OR THE MEMBER/PATIENT'S REPRESENTATIVE MUST READ AND SIGN OR INITIAL THE FOLLOWING STATEMENTS:

I understand that this authorization will expire**:**

☐ On ____/____/____ (MM/DD/YY), or upon termination of policy coverage, or 60 days after the termination of treatment, whichever is earlier.

OR

☐ Once the following event occurs:

(Form <u>must</u> be completed before signing)

Signature of Member/Patient/Legal Guardian or Member/Patient's Representative — Date

Signature of Minor Member/Patient — Date

Print Name of Member/Patient's Representative — Relationship to the Member/Patient

The patient or the person signing this form has the right to receive a copy of the Consent Form. A copy of this form has been requested and received:

_____ Yes _____ No **Initials**: _____ (patient)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION