



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. _____ 2. ____ / ____ / _____
Name **Date of Birth**
3. _____ 4. (____) ____ - _____
Address **Home Phone Number**
5. _____ 6. _____
Name of Member **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:
 ____ / ____ / _____

