



**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

By completing this form you allow ValueOptions, Inc. 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” for a reason):**

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:**

\_\_\_\_ All Health Information (*except the health information listed below*); or  
\_\_\_\_ Other (please describe, you may limit by provider, date span, service type, etc.) \_\_\_\_\_  
\_\_\_\_\_

**By initialing the following items, you are authorizing ValueOptions to release the following specific types of information to the person(s) identified in Section 2 above:**

- \_\_\_\_ HIV/AIDS related information and/or records
- \_\_\_\_ Mental health information and/or records
- \_\_\_\_ Alcohol or substance use information and/or records

**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. You have a right to revoke this authorization at any time by sending written notice to:

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

Revoking this authorization will not have any effect on actions that ValueOptions takes prior to receiving the notice of revocation. The information disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws. 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\*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

*\* 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.*