AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

This authorization must be dated and signed by the individual whose information will be released or by a person who is legally authorized to act on the individual's behalf. Do not use this form if you are requesting health information for personal use. ValueOptions® has a separate form for that type of request and you should contact ValueOptions® at (800) 235-2302 to obtain a copy of that form.

Once completed and signed, this authorization will remain in effect until the earliest of (a) the date you specify below; (b) one year from date signed; or (c) the date you withdraw your permission. ValueOptions® cannot process partially completed forms; incomplete forms will be returned.

Mail the completed form to:

ValueOptions®
Clinical Department
48561 Alpha Drive Suite 150
Wixom, MI 48393

Or fax it to: **(248) 697-0908**

I, the Undersigned, Authorize:
ValueOptions®
To Release Mental Health Information from the Records of:
Individual/Member Name: ______________________________
Member Identification Number: ______________________________
Member Date of Birth: ___ ___/ ___ ___/ ___ ___ ___ ___

The Mental Health Information Authorized for Release includes: (check all that apply)

Claims Information: *includes payment related information such as billed amount, paid amount, claim payment or denial reasons, etc.*

Service Determination Information: *includes clinical information related to pre-service, concurrent and post service certification decisions and/or care management activities*

❑ Claims Information (from _______ to________)
❑ Claims Information for provider:

____
Provider Name (include dates if applicable)

❑ Service Determination Information (from _______ to________)
❑ Service Determination Information for provider:

____
Provider Name (include dates if applicable)

❑ Other information *(describe below)*

____

Person Information may be Released to and Purpose:

Person/Organization authorized to receive your information	Relationship	Purpose
______________________ *Name*	______________________	______________________
______________________ *Address*		______________________
______________________ *City/State/Zip*		______________________

OPTIONAL: Authorization termination date: __ __/ __ __/ __ __ __ __(*must be less than one year from date signed, if no date is specified the authorization will terminate one year from the date of signature or sooner if required by state law*)

Complete and Sign the following for Alcohol and/or Drug Abuse Records:

I acknowledge that information to be used or disclosed as a result of this Authorization may include records that are protected by other federal and/or state laws applicable to substance abuse. **I SPECIFICALLY AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION RELATING TO DRUG AND/OR ALCOHOL ABUSE.** The recipient of drug and/or alcohol abuse information disclosed as a result of this Authorization will need my further written authorization to re-disclose this information. 42 CFR §2.32 restricts any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

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

Print Name: ______________________________

Parent/Guardian Signature (if required by State Law) Date

I Understand and Agree to the following:

- 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;
- 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®**.** ValueOptions® does not accept partial revocations. If you wish to partially revoke this authorization, please submit a revocation and new authorization specifying the information you are authorizing for disclosure.
- 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

Print Name: ______________________________

Relationship to the Individual/Member:

❑ 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: _____