# Authorization for Beacon Health Options to Release Confidential Information

***Important:*** By completing all sections of this form you allow Beacon Health Options, Inc. (Beacon) to disclose health care information to the individuals you identify for up to one year. Completion of this form allows Beacon to share information with your family, providers, legal representative, or **anyone** that you wish to have access to this information. Please fill in all sections as incomplete forms may be returned.

*Please note: It is also important for your doctor to have access to your medical information to ensure you receive the best care possible. The purpose of sending the health information to your doctor is to assist in identifying any follow-up medical care that may be needed. To allow us the ability to send your health information to your doctor, complete and sign the release of information below. We will only send information that pertains to your care.*

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

I, _____ **(Member Name)** authorize Beacon Health Options, Inc. (or any Beacon Health Options subsidiary holding my information) to disclose my health care information as described below.

**Additional Member Identifying Information** Member ID#: _____ DOB: ____/____/____

Phone Number: _____ Name of Health Plan: Gold Coast Health Plan

## SECTION 2: IDENTIFY THE PERSON, PROVIDER, OR ENTITY TO RECEIVE THE INFORMATION

Print the Name(s) of person or organization who will be receiving my information and contact information (if known):

Ventura County Human Services Agency Child Welfare Services

Phone Number of the Recipient: 805-240-2700

## SECTION 3: IDENTIFY THE REASON WHY THE INFORMATION SHOULD BE RELEASED (THE REASON MAY BE "AT MY REQUEST")

Reason: _____

If known: ☒ Care Coordination/Management ☐ Claim Assistance ☐ Quality of Care Review

☐ Other (Please explain reason): _____

## SECTION 4: 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 **(INITIALS REQUIRED!)**

____ Alcohol or substance use information and/or records **(INITIALS REQUIRED!)**

____ HIV/AIDS related information and/or records **(INITIALS REQUIRED!)**

____ Other health information, please specify **(INITIALS REQUIRED!)**: _____

Special instructions, if any (you may specify provider, date span, service type, etc.): _____

_____

## SECTION 5: IDENTIFY HOW LONG YOU WOULD LIKE THIS AUTHORIZATION TO LAST (up to one year)

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

## SECTION 6: 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 if that happens, it might no longer be protected by federal privacy laws.
- You have a right to revoke this authorization at any time. ***But if you revoke this authorization, the revocation will not affect the disclosure of any information that Beacon has already sent to the recipient***.

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 Member or the Member's Legally Authorized Representative* Date

_____

Print Name

**** NOTE: If you are signing as the individual'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.*** **A financial or business power of attorney is NOT sufficient.**

**Please contact the phone number for behavioral health, mental health, or substance use services on your medical ID card with any questions or to determine where to mail or fax your request.**