Authorization for Provider to Release Confidential Information to Beacon Health Options

I,_____ (Member Name) ___/___/___ (Date of Birth) authorize Beacon to
☐ Request from and authorize: _____
(Name/Address or Phone Number) to release/disclose to Beacon Health Options: _____
_____

Method of Release
☐ Telephone/Verbal (Telephone #) _____ ☐ U.S. Mail/In-person
☐ Fax # _____

I CONSENT TO THE RELEASE OF THE SPECIFIC INFORMATION CHECKED OFF BELOW:

☐ Discharge summary ☐ Psychological testing results ☐ Psychiatric Evaluation ☐ Progress Notes
☐ Laboratory data ☐ Complete Medical Record ☐ History and Physical ☐ Treatment Plan ☐ Alcohol and Drug Abuse Information ☐ History of Mental Health Treatment ☐ HIV/AIDS Information ☐ Other (Please be Specific)
_____

***Please note information not specifically checked above is not to be released**

For date(s) of service: From: _____ To: _____

THIS INFORMATION IS NEEDED FOR THE FOLLOWING PURPOSE(S):

☐ Coordination of Care ☐ Case Management ☐ Patient Care ☐ Quality of Care Review ☐ Other (Specify) _____
_____

I understand that my records are protected under state and federal law and cannot be disclosed without my written consent except as otherwise specifically provided by law. Further, I understand that if my records involve alcohol or drug abuse, they are also protected under Federal Regulation 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records. I also understand that disclosure of HIV/AIDS related information may only be: (1) limited to specific circumstances: and/or (2) restricted by me.

I have read carefully and understand the above statements and expressly and voluntarily consent to disclosure of my confidential health care information (including alcohol and drug abuse records of my condition and HIV/AIDS information, if checked above) to those persons/agencies named above.

I understand that I may withdraw and revoke this consent at any time by notifying Beacon Health Options, either orally or in writing, at the following address:
_____.

However, my withdrawal/revocation will not affect the rights of anyone acting in reliance on this consent prior to notice of the withdrawal/revocation. Unless otherwise revoked, this consent will expire on the following date, event or condition:_____. If I fail to specify an expiration date, event, or condition, this consent will remain valid for not more than twelve (12) months from the date this consent was signed.

Beacon will not condition payment, treatment, enrollment or eligibility for benefits on whether I sign this authorization. I am aware that the information disclosed as part of this authorization and contained in my record may be given to another agency/person if requested.

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Beacon will not condition payment, treatment, enrollment or eligibility for benefits on whether I sign this authorization. I understand that by not signing this form, the services provided to me by Beacon may be limited if benefits cannot be determined. I am aware that the information disclosed as part of this authorization may be re-disclosed and no longer protected under federal or state law.

_____ _____
Signature of Patient, Legal Guardian or Parent Date

_____ _____
Relationship if not Patient, or if Patient is under 18 Date

_____ _____
Signature of Patient, if under 18 Date

_____ _____
Witness Date

This information is needed for the following purpose(s):

☐ Coordination of Care ☐ Case Management ☐ Patient Care ☐ Quality of Care Review ☐ Other (Specify) _____
_____

I understand that my records are protected under state and federal law and cannot be disclosed without my written consent except as otherwise specifically provided by law. Further, I understand that if my records involve alcohol or drug abuse, they are also protected under Federal Regulation 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records.

I have read carefully and understand the above statements and expressly and voluntarily consent to disclosure of my confidential health care information (including alcohol and drug abuse records of my condition and HIV test results, if checked above) to those persons/agencies named above.

I understand that I may withdraw and revoke this consent at any time by notifying Beacon Health Options, either orally or in writing, at the following address: _____. However, my withdrawal/revocation will not affect the rights of anyone acting in reliance on this consent prior to notice of the withdrawal/revocation. Unless otherwise revoked, this consent will expire on the following date, event or condition: _____. If I fail to specify an expiration date, or condition, this consent will remain valid for not more than twelve (12) months from the date this consent was signed.

_____ _____
Signature of Patient, Legal Guardian or Parent Date

_____ _____
Relationship if not Patient, or if Patient is under 18 Date

_____ _____
Signature of Patient, if under 18 Date

_____ _____
Witness Date

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Authorization for Behavioral Health and Primary Care Physician to Share Confidential Information

MEMBER CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, _____ (Member Name) give permission to _____ (Behavioral Health Provider) and my Primary Care Physician _____ (Primary Care Physician) to share information about my diagnosis and / or treatment related to substance abuse, mental health, or medical history, NOT including the results of a blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care.

This consent form expires 90 days from the date of signing and I can choose to cancel it at any time.

_____ _____
Member/Guardian/Authorized Representative Date

_____ _____
Witness Date

Member Refusal to Release Confidential Information

I, _____ (Member Name) **DO NOT** give permission to _____ (Behavioral Health Provider) and my Primary Care Physician _____ (Primary Care Physician) to share information about my diagnosis and / or treatment related to substance abuse, mental health, or medical history, including the results of a blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care. I also understand that my refusal to share information does not affect my insurance coverage.

_____ _____
Member/Guardian/Authorized Representative Date

_____ _____
Witness Date

This consent form expires 90 days from the date of signing and I can choose to cancel it at any time.

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Authorization to Release Confidential Information

I,_____ (Member Name) ___/___/___ (Date of Birth) authorize Beacon to disclose my health information to:_____

_____.

(Name/Address or Phone Number)

I CONSENT TO THE RELEASE OF THE HEALTH INFORMATION INITIALED BELOW:

☐ All information in Beacon's file

☐ Only information checked below

☐ Billing Information ☐ Case Management Notes ☐ Member Services Records ☐ Grievance Information ☐ Authorizations for Treatment ☐ Documentation relating to Appeals ☐ Utilization Management Records

☐ Other (Specify): _____

I may revoke this consent at any time by notifying Beacon in writing to the address on my Member ID card. Consent for alcohol or substance use disorder records may be revoked by calling Beacon at the number on my Member ID card. *

Revoking my consent will not affect the rights of anyone acting in reliance of this consent prior to notice of the revocation. Unless revoked, this consent will expire on the following date, event or condition:

_____.

Otherwise, this consent will remain valid for twelve (12) months from the date this consent was signed.

Beacon will not condition payment, treatment, enrollment or eligibility for benefits on whether I sign this authorization. I understand that by not signing this form, the services provided to me by Beacon may be limited if benefits cannot be determined. I am aware that the information disclosed as part of this authorization may be re-disclosed and no longer protected under federal or state law.

_____ _____

Signature of Member/Member's Legally Authorized Representative** Date

_____

Print Name

Relationship to Member: _____

* If you have any questions on how to revoke this authorization please contact compliance@beaconhs.com

** If you are signing as the Member's Legally Authorized Representative, please attach the appropriate legal document(s) granting you the authority to do so (for example, Health Care Power of Attorney, Court Order, Guardianship, etc.)