Authorization for Release of Information

Member Name	Last 4 digits of Social Security #	Date of Birth	Provider ID # *(For use by Vaya records staff only)*

(1) I, _____, AUTHORIZE THE RELEASE, SHARING AND EXCHANGE OF INFORMATION BETWEEN **VAYA HEALTH** AND THE **INDIVIDUALS AND/OR ENTITIES LISTED BELOW**.

(2) The information to be released, shared and exchanged is as follows:

- ☐ Medical/Psychiatric Information included in a designated record set under 45 CFR § 164.524(a). This may include diagnoses, progress notes, diagnostic assessments, person-centered plans, individual support plans, care plans, treatment and medical history, medications, discharge summaries, laboratory data, Medicaid/Medicare eligibility information, resource allocation budgets, SIS assessments, and other information used to coordinate services.
- ☐ Financial Information (for example, records of payments made to providers; explanation of benefit forms)
- ☐ Psychotherapy Notes _____ (Initials required) ☐ Genetic Information _____ (Initials required)
- ☐ HIV and/or AIDS-Related Information _____ (Initials required)
- ☐ Substance Use Information _____ (Initials required) This is information that may identify me as a person with a substance use diagnosis (drugs or alcohol) or someone who has received substance use treatment in the past. I understand that my substance use treatment records are protected under federal regulations governing Confidentiality of Substance Use Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- ☐ Other: _____
- ☐ Other: _____

NOTE: Once this authorization is completed and signed, it cannot be altered or changed in any way. If you wish to change this authorization, it must be revoked, and you must complete and sign a new authorization.

(3) The purpose of the Release is one of the following:

- ☐ Care Coordination, including but not limited to sharing with Community Care of NC and service providers
- ☐ Legal Reasons (e.g., guardianship, appeals, worker's compensation, social services, concealed carry permit)
- ☐ At my request or request of my Legal Representative
- ☐ Other: _____

(4) RECORDS REQUESTS. Note that records requested may include information from providers, which may be incomplete. Please contact your provider for complete information.

a. The information requested is:

- ☐ As listed above; or
- ☐ Information identified in the attached document(s). Please attach any subpoena, cover letter from your attorney or other document.

b. Please release the requested information in the following manner:

- ☐ Paper documents mailed by regular U.S. mail, sent to the mailing address(es) listed below; or
- ☐ By Facsimile to Fax Number (please include area code): (_____) _____ - _____
- ☐ Electronic documents sent by electronic mail, to the following e-mail address: _____
  ****Note that e-mailed documents will be encrypted for security purposes and will require the recipient to set up a password for access.**

c. Date range of records being requested: _____

(5) I understand the *recipient of these records may not protect my information from re-disclosure* ***except*** where this information includes substance use diagnosis or treatment information; **in that case the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.**

(6) I understand that, if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, substance use, psychotherapy notes or genetic testing, this disclosure will **NOT** include that information **UNLESS** I added my initials next to each item to be disclosed. I further understand that if I am requesting Vaya to release my psychotherapy notes to me, that I must contact my treating provider to obtain these notes.

(7) I also understand I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment or payment for my services. I understand that my health information is shared between my provider and Vaya Health for purposes of treatment, payment and healthcare operations unless I specifically revoke authorization for those purposes. I understand that I may be discharged and/or denied services if I revoke consent to a disclosure for such purposes.

(8) I understand if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose, or for up to one year from the signature date, whichever is earlier. I also understand I may revoke this authorization at any time in writing. I further understand any action taken on this authorization prior to the date I revoke it is legal and binding.

(9) I further understand I will be given a copy of this form once this authorization has been completed.

_____	_____	_____	_____
Signature	Printed Name	Date Signed	Expiration Date *(up to one year if blank)*
_____	_____	_____	_____
Signature of Legal Representative	Relationship to Member	Date Signed	Expiration Date *(up to one year if blank)*

Contact Telephone Number for Person Signing (please include area code): (_____) _____ - _____

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RECIPIENTS (All items must be completed – Please print clearly)		
Name: _____ Address: _____ _____ _____ Phone: (_____) _____ - _____ E-mail Address: _____	Name: _____ Address: _____ _____ _____ Phone: (_____) _____ - _____ E-mail Address: _____	Name: _____ Address: _____ _____ _____ Phone: (_____) _____ - _____ E-mail Address: _____
Name: _____ Address: _____ _____ _____ Phone: (_____) _____ - _____ E-mail Address: _____	Name: _____ Address: _____ _____ _____ Phone: (_____) _____ - _____ E-mail Address: _____	Name: _____ Address: _____ _____ _____ Phone: (_____) _____ - _____ E-mail Address: _____

REVOCATION OF AUTHORIZATION

AUTHORIZATION REVOKED BY: _____ Date: _____
(Signature of authorized person) (Revocation effective on date of signature)