Authorization for Beacon Health Strategies to Release Confidential Information

I, ______________________________________ Date of Birth _____________________

Authorize Beacon Health Strategies (BHS), an organization contracted with College Health IPA (CHIPA) to provide management services, to release/disclose following information to:

(Name/Address) ____

□ PCP □ BH Provider □ Parent □ Relative □Other

If other, please specify: __________________________

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.

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I have read carefully and understand the above statements and expressly and voluntarily consent to disclosure of the 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 Strategies, either orally or in writing, at the following address:

Beacon Health Strategies, 5665 Plaza Drive #400, Cypress, CA 90630-5023

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.

BHS 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 might be subject to disclosure by the recipient and no longer be protected.

____	______________
(Signature of Patient/Legal Guardian/Parent)	(Date)
____	______________
(Relationship if not Patient, or Patient under 18)	(Date)
____	______________
(Signature of Patient, if under 18)	(Date)
____	______________
(Witness)	(Date)