

Authorization for Release of Information

Social Security # Profession (and provide records state) with a solution of the soluti	Member Name	Last 4 digits of	Date of Birth	Provider ID #	
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Substance Use Information (initials required) This is information that may identify the as a person with a substance use diagnois (diagnois			(Initials required)		
or concense who has received substance use treatment in the past. I understand that my substance use treatment reconstributed and accountability Act of 3996 [HPAA), As C.F. Parts 150 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. [HPAA), As C.F. Parts 150 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. [HPAA), As C.F. Parts 150 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. [HPAA), As C.F. Parts 150 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. [IPAA, SC.F.P. Parts 150 and 164, and cannot be disclosed without my way. If you wish to change this authorization, it must be revoked, and you must complete and sign a new authorization. [IPA purgues of the Releases is one of the following: [Legal Reasons (ee., guardianship, appeals, worker's compensations, social services, concealed carry permit) [Legal Reasons (ee., guardianship, appeals, worker's compensations, social services, concealed carry permit) [Legal Reasons (ee., guardianship, appeals, worker's compensations, social services, concealed carry permit) [Legal Reasons (ee., guardianship, appeals, worker's compensations, social services, concealed carry permit) [Legal Reasons (ee., guardianship, appeals, worker's compensation from providers, which may be incomplete. Please contact your provider for complete information. [Legal Reasons (ee., guardianship, appeals, worker's compensation from providers, social service, concealed carry permit) [Legal Reasons (ee., guardianship, appeals, worker's compensation from providers, which may be incomplete. Please contact, your provider for complete information requested is: [Legal Reasons (ee., guardianship, appeals, worker's compensation, social services, concealed carry permit) [Legal reflexes the requested			identify meas a nercon with a	substance use diagnosis (drugs or alcohol)	
and you must complete and sign a new authorization. (3) The purpose of the Release is one of the following:	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.				
Care Coordination, including but not limited to sharing with Community Care of NC and service providers Legal Reasons (e.g., guardianship, appeak, worker's compensation, social services, concealed carry permit) At my request or request of my Legal Representative Other:		nnot be altered or changed in a	ny way. If you wish to change	this authorization, it must be revoked,	
Care Coordination, including but not limited to sharing with Community Care of NC and service providers Legal Reasons (e.g., guardianship, appeak, worker's compensation, social services, concealed carry permit) At my request or request of my Legal Representative Other:	(3) The purpose of the Release is one of the following:				
At my request or request of my Legal Representative CH: (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: b. At itsed above: or c. 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: c. Date realese the requested information in the following e-mail 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. Information includes substance use diagnosis or treatment information information information relating to HV infection, ADS or AIDS-related conditions; substance use, substance use diagnosis or treatment information information relating to HV infection, ADS or AIDS-related conditions; substance use or append that if 1 am requesting Vays to release my psychotherapy notes to me, that I must contact my treating provider to obtain these notes. (6) I understand that my refuse to sign this authori		ing with Community Care of NC	and service providers		
Other:	Legal Reasons (e.g., guardianship, appeals, worker's	compensation, social services,	concealed carry permit)		
(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:	At my request or request of my Legal Representativ	e			
information. a. The information requested is: b. Stated 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: b. Please release the requested information in the following manner: c. Date range of records being requested: c. Date range of records being requested: c. Date range of records being requested: (5) I understand the <i>recipient of these records may not protect my information from re-disclosure</i> except where this information includes subtance use diagnosis or treatment information; in that case the recipient may not re-disclosuse 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. If urther understand that if I am requesting Vaya to release my psychotherapy notes to sign this authorization and my refusal to sign will not affect my ability to obtain these notes. (7) I also understand that, if my record contains information withorization sign will not affect my ability to obtain there notes. (7) I also understand that, information is shared between my provider and Vaya Health for purposes of treatment, payment and healthcare operations unless I specifically revoke authorization for tho	Other:				
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: By Facsimile to Fax Number (please include area code): (
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): ()					
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**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 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 has been completed. (9) I further understand I will be given a copy of this form once this au					
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	Signature of Legal Representative Relationship to	Member Dat	e Signed	Expiration Date (up to one year if blank)	
	Contact Telephone Number for Person Signing (please include area code): () -				



Authorization for Release of Information

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

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