NETWORK HEALTH

Consent to Release Information Form

Fax to: 888-977-0776

Today's date ___ /___ /____

Member information

Member name ____________________ Member ID # ______________ DOB ___ /___ /___

☐ **State agency** ☐ **Family member** ☐ **Other**

Name ______________________________

Relationship to member ______________________________

Address ______________________________

City ______________________ State _______ ZIP __________

Phone ____ - ____ - ________ Fax ____ - ____ - ________

I, (or on behalf of) ______________________________
(print member name and address)

give permission to Network Health to exchange information about my medical history with individuals or organizations listed above. This includes my diagnosis and/or treatment related to alcohol abuse, substance abuse, mental health, or psychiatric care. This does NOT include results of any blood test for HIV antibodies or any other HIV- or AIDS-related information. The purpose of this consent to release information is to allow the individuals or organizations to assure continuity of care among my health care providers including to carry out discharge planning arrangements; to carry out utilization review and quality assurance activities; to determine clinical eligibility for covered benefits; and to make payment decisions.

Any limitations about the consent to release information, are as follows ______________________________

I may cancel this agreement at any time except if the information has already been released. If not canceled, this agreement will end one year from the date written below.

Signature of witness ______________________________ Date ___ /___ /___

Signature of member/guardian/authorized representative ______________________________ Date ___ /___ /___

Refusal to release information

☐ I do not consent to release the information as described above. However, I understand that if I do not allow my providers to exchange information about me, their ability to fully coordinate my care may be limited. I understand that in an emergency situation my providers may exchange information about me to the extent necessary.

Signature of witness ______________________________ Date ___ /___ /___

Signature of member/guardian/authorized representative ______________________________ Date ___ /___ /___

Note to person receiving alcohol and substance abuse-related information. This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making further disclosure from this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CRF part 2. A general authorization for the release of medical or information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse treated patient.