Ventura County Health Care Plan

INSTRUCTIONS: You must complete all information below. If incomplete, this authorization will be returned. If you have any questions or need assistance completing this form, please contact Customer Service at (805) 981-5050. This form consists of 2 pages.

Member/Patient Name: _____ Date of Birth: _____

VCHCP Member Number: _____ Telephone: _____

Address: _____
Number and Street City State Zip Code

Section 2 Important Information about this Authorization to Release Information

- **Purpose**—I authorize the Ventura County Health Care Plan (VCHCP), including, but not limited to, Express Scripts, Inc. and OptumHealth Behavioral Solutions to give the information listed in Section 3 below to the authorized person(s) named in Section 4. I have requested this information to be given to the authorized person(s) for the purpose of responding to an inquiry regarding my health benefits.
- **Indemnity**—I hereby release VCHCP, its subsidiaries, affiliates, employees, officers and agents including, but not limited to, Express Scripts and Magellan Behavioral Health from any and all liability associated with the release of such information and records to the authorized person, and further agree to indemnify and hold VCHCP harmless, and defend VCHCP in court, if necessary, from any claims arising out of any release of information pursuant to this authorization.
- **Voluntary Authorization**—This authorization is voluntary. VCHCP will not condition my enrollment, eligibility for **benefits or payment of claims on giving this authorization.**
- **Re-disclosure of Information**—I understand that the authorized person(s) who receives my protected health information under this authorization may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.
- **Psychotherapy Notes**—I understand that this authorization does not provide for the release of psychotherapy notes and that I ***must complete a separate form,*** Authorization to Release Psychotherapy Notes, for this purpose. Psychotherapy notes are notes created by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. **This form is available from OptumHealth Behavioral Solutions** by calling (800) 851-7407.

Please check one of the boxes below. If you do not select anything, VCHCP will release General Health Care Information as described below.

General Health Care Information—VCHCP may disclose to the authorized person(s) all of the information and records that could be given to me upon my request. **This may include medical and mental health information and information relating to treatment for alcohol or substance abuse, HIV/AIDS and/or sexually transmitted disease(s).**

Other— (Please be specific. You may identify information by date of service, name of provider, or specific diagnosis):

_____

_____

_____

Section 4. Authorized Person(s) – authorization may only be granted to an individual, not to an organization.

Provide the information below for each person that is authorized to receive your protected health information identified above. Please include a complete address and specify the relationship to the patient. Please print.

Name:

Organization (if applicable):

Address: _____
Street or Post Office Box

_____
City State Zip Code

Telephone: _____

Relationship to Patient: _____
i.e. mother, attorney , neighbor, friend, benefits administrator representative

Name:

Organization (if applicable):

Address: _____
Street or Post Office Box

_____
City State Zip Code

Telephone: _____

Relationship to Patient: _____
i.e. mother, attorney , neighbor, friend, employer

Section 5. Expiration

Unless revoked, this authorization is valid from the date of my signature until the date I am no longer insured by VCHCP or upon the date written below (if any), whichever occurs first. This authorization will automatically terminate upon my death.

This authorization shall terminate on (specify date, if applicable) _____.*

*Any authorization concerning a minor under the age of twelve will automatically expire upon the minor's tw elfth birthday. The minor may complete an authorization upon such expiration.

Section 6. Revocation

I understand that I may revoke this authorization at any time by mailing ***written*** notice of my revocation to VCHCP ATTN: Privacy Officer at 2200 E. Gonzales Rd. #210-B; Oxnard, CA 93036. I understand that revocation of this authorization will *not* affect any action VCHCP, its employees, officers and agents including, but not limited to, Express Scripts and OptumHealth Behavioral Solutions in reliance on this authorization before it received my written notice of revocation.

Section 7. Signature

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to VCHCP. I understand that, by signing this form, I am confirming my authorization that VCHCP, its employees, officers and agents including, but not limited to, Express Scripts and OptumHealth Behavioral Solutions may use and/or disclose the protected health information described in this form to the authorized person(s) named above.

Member/Patient Signature**: _____ Date: _____

****If the Member/Patient is a minor aged 12 through 18, he/she must authorize the release of certain protected health information even if a parent or legal guardian is requesting the information. If the authorized person is anyone other than the parent, and the authorization is for information *other than* treatment for mental health, substance abuse and/or sexually transmitted disease, the parent must also sign this authorization. The parent should sign as a personal representative, below.**

If you are a personal representative (Parent, Legal Guardian, agent acting under a Durable Power of Attorney for Health Care, or Executor or Administrator of Estate) signing on behalf of the Member/Patient, complete the following and attach documentation (if applicable) supporting such personal representation:

Personal Representative's Name: _____

Relationship to Member/Patient or Authority to act as Personal Representative: _____

Please keep a copy of this document for your records and mail the completed Authorization to VCHCP at the address shown above. Or fax to (805) 981-5126.