Vaya Partners

Authorization for Release of Information

Member name	Last four digits of SSN	Date of birth

1. I, _____, AUTHORIZE THE RELEASE, SHARING, AND EXCHANGE OF INFORMATION BETWEEN **VAYA PARTNERS** 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, Supports Intensity Scale assessments, and other information used to coordinate services.
   - ☐ Financial information (e.g., records of payments made to providers, explanation of benefit forms)
   - ☐ Psychotherapy notes _____ *(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 as 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 Disorder Patient Records (42 CFR Part 2), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and 45 CFR Parts 160 and 164 and may be redisclosed under this consent and in compliance with current HIPAA regulations. 42 CFR Part 2 prohibits unauthorized use or disclosure of these records.
   - ☐ 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 or scope of this release – please select all that apply UNLESS for selecting substance use information disclosure for civil, criminal, administrative, or legislative proceedings:
   - ☐ Care coordination/treatment, payment, and healthcare operations
   - ☐ At my request or request of my legal representative
   - ☐ Legal reasons (e.g., guardianship, appeals, worker's compensation, social services, or civil, criminal, administrative or legislative proceedings)
   - ☐ For substance use information only: civil, criminal, administrative, or legislative proceeding against me **(if selected, do not select any other purpose)**
   - ☐ 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 sent by regular U.S. mail to the mailing address(es) listed below; or
      - ☐ By fax to _____ (include area code); or
      - ☐ Electronic documents emailed to the following address: _____
        Note that emailed documents are 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* and that where this information includes substance use diagnosis or treatment information, the recipient may re-disclose such records or information contained in such records in accordance with the permissions contained in the HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against me.

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Member name: _____ DOB: _____

6. I understand that, if my record contains information relating to AIDS or AIDS-related conditions, substance use, or psychotherapy notes, 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 Partners to release my psychotherapy notes to me, 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 Partners 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, except to the extent that Vaya Partners or other lawful holder of my information that is permitted to make the disclosure has already acted in reliance on it. 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)*

Recipients (All items must be completed. Please print clearly)

☐ My treating providers, health plans, and third-party payor(s) _____ *(initials required)*

☐ Potential healthcare provider(s) identified by Vaya Partners for purposes of diagnosis, referral, or treatment _____ *(initials required)*

Name: _____ Email: _____
Address: _____ Phone: _____

Name: _____ Email: _____
Address: _____ Phone: _____

Name: _____ Email: _____
Address: _____ Phone: _____

Name: _____ Email: _____
Address: _____ Phone: _____

Name: _____ Email: _____
Address: _____ Phone: _____

Name: _____ Email: _____
Address: _____ Phone: _____

Name: _____ Email: _____
Address: _____ Phone: _____

Revocation of Authorization

AUTHORIZATION REVOKED BY:

_____ Date: _____

Signature of authorized person *Revocation effective on date of signature*

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