Employer/Health Plan: _____

INTEGRATED BEHAVIORAL HEALTH

PO Box 30018, Laguna Niguel, CA, 92607-0018 • (800) 395-1616 • Fax (714) 556-5430

AUTHORIZATION TO RELEASE BEHAVIORAL HEALTH, DRUG OR ALCOHOL ABUSE INFORMATION

Authorization: I am the plan holder for behavioral health benefits provided by _____(**employer**). I am authorizing Integrated Behavioral Health to communicate with and release private health information for _____(**patient**) to the following person(s) who are not eligible for these benefits. This includes information, including but without limitation, from evaluating and treating physicians, psychologists, behavioral health counselors, drug and alcohol counselors, hospitals, pharmacists, and designated IBH representatives (to disclose information such as benefits, referrals, authorizations and recommendations for treatment). Person(s) authorized to receive information:

_____	_____	_____
Name	Relationship to patient	Address
_____	_____	_____
Name	Relationship to patient	Address

Confidentiality: I understand that this information may be protected as confidential under state and federal laws and federal regulations, including 42 CFR Part 2, and may include a history of drug or alcohol abuse, mental health treatment, or testing or treatment for Acquired Immune Deficiency Syndrome ("AIDS"). IBH agrees this information will not be disclosed to other parties, except as stated in this release, without your expressed written consent. IBH communication with providers is covered under a separate authorization by the patient or the patient's legal representative.

Purposes: I understand that the communication and/or release of information will be used by IBH and the above named party for the following purpose (please check all that apply):

_____ 1. to allow active involvement in the case management, decision-making and treatment process
_____ 2. to provide clinical and claims information only to the above-referenced party
_____ 3. to provide only claims information
_____ 4. other purposes noted below:

_____

Revocation: I further understand that this consent is subject to revocation at any time if I give written notice to Integrated Behavioral Health. If this authorization is revoked, the revocation will not affect action that has been taken based on this authorization while effective. If not revoked, this consent will terminate two years from the signing of this agreement.

Release: By signing this authorization to release Records, I release IBH, its officers, agents, directors, employees, and assigns, from Liability based on breach of the privilege of physician/patient and private health information confidentiality.

I authorize copies of this release to be used as if they were an original.

_____ _____
Signature of Planholder(insured) or Legally Authorized Representative *Date*

_____ *Planholder/insured ID (SS#)* _____
Printed Name

_____ _____
Witness *Date*

NOTICE

THIS INFORMATION HAS BEEN DISCLOSED FROM CONFIDENTIAL RECORDS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42 CFR Part 2) and HIPAA (45 CFR Parts 160 and 164) PROHIBIT ANY FURTHER DISCLOSURE OF THIS CONFIDENTIAL INFORMATION WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.

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