Life Strategies™
offered by U. S. Behavioral Health Plan, California

Authorization for Release of Information

Member's Name	Date of Birth	Member or Subscriber ID #

Member's Street Address	City	State	Zip Code

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider the information may no longer be protected by the Federal privacy regulations.

I understand that my health information may contain information created by other persons or entities including health care providers, and may also contain drug and alcohol, mental health, HIV/AIDS, psychotherapy, genetic, reproductive and sexually transmitted disease information. I further understand that by signing this document, I am authorizing the release or exchange of this information with the person or organization named below.

I understand that my health plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this authorization at any time by notifying Life Strategies in writing. However, the revocation will not have an effect on any actions Life Strategies took before it received the revocation.

I authorize Life Strategies to receive from or disclose my individually identifiable health information to the following person(s) or organization(s):

Name: _____

Address: _____

City	**State**	**Zip**

Phone Number: (___) _____ Extension _____

Description of individually identifiable health information to be received or disclosed (check appropriate type(s) of information):

- ☐ All relevant information related to my healthcare services
- ☐ Claims
- ☐ Eligibility/Benefits
- ☐ Information used to make benefit determinations
- ☐ Health Care Programs – Care Solutions, Behavioral Health, Disease Management
- ☐ Treatment Plan(s)
- ☐ Progress Reports
- ☐ EAP Participation
- ☐ Other (describe): _____

The purpose of this authorization is (check all that apply):

☐ To allow the appropriate management of treatment, services, and/or coverage under the member's benefit plan.
☐ Benefit Management
☐ Claims Administration/Payment
☐ Employer Mandated Treatment Referral
☐ Other (describe): _____
☐ Administration of a Worker's Compensation claim
☐ Administration of a Disability claim
☐ Subpoena or other legal process

All dates of records will be disclosed unless you indicate differently below.

From _____ (MM/DD/YYYY) To _____ (MM/DD/YYYY)

THE MEMBER OR MEMBER'S REPRESENTATIVE MUST COMPLETE THE REST OF THIS FORM:

I understand that this authorization will expire:

☐ On _____ (MM/DD/YYYY) or one year from the date of the signature below (or as set forth in the applicable state-specific provisions below).

OR

☐ Once the following event occurs:
_____

_____ _____
Signature of Individual Date

Please note: If you are a guardian or court appointed representative for the individual, you must attach copies of your authorization to represent the individual in order to obtain access to his/her Protected Health Information.

_____ _____
Signature of Individual's Representative Date

Personal Representative's Name_____

Address_____

City_____ State _____Zip _____Phone (_____) -_____

Relationship to individual and authority to act for individual:

_____

I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it.

A copy of this form has been requested and received: _____ Yes _____ No

PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS

Insurance Benefit Plans

English

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health plan. To get an interpreter or to ask about written information in (your language), first call your health plan's phone number at 1-800-985-2410.
Someone who speaks (your language) can help you. If you need more help, call the CA Dept. of Insurance at 1-800-927-4357

Español

IMPORTANTE: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o plan de salud. Para obtener la ayuda de un intérprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su plan de salud al 1-800-985-2410.
Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame al Departamento de Seguros de California al 1-800-927-4357
(Spanish)

中文

請注意：您可以免費取得口譯員服務，與您的醫師或醫療保險計畫聯絡。
欲取得口譯員服務或詢問中文的書面資料，請先致電您的保健計畫，電話號碼 1-800-985-2410
我們有會説中文的人為您服務。若您需要其他協助，請致電 1-800-927-4357 與加州保險局聯絡。
(Chinese)

HMO Benefit Plans

English

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-800-985-2410.

Español

IMPORTANTE: ¿Puede leer esta carta? Si no, alguien le puede ayudar a leerla. También puede recibir esta carta escrita en su propio idioma. Para obtener ayuda gratuita, llame ahora mismo al 1-800-985-2410.
(Spanish)

中文

請注意：您是否能閱讀此信件？若您無法閱讀此信，我們將為您提供專員服務。
您也可以取得本信件的中文書面翻譯。欲洽詢免費服務，請立即致電 1-800-985-2410
(Chinese)