VENTURA COUNTY HEALTH CARE PLAN

Authorization to Release Protected Health Information

INSTRUCTIONS:

You must complete all information. If incomplete, this authorization will be returned. If you have any questions or need assistance completing this form, please contact Member Services at (805) 981-5050.

Section 1: Member/Patient Information

Member/Patient Name:	Date of Birth:
VCHCP Member Number:	Phone Number:
Street Address:	
City:	Zip Code:

Section 2: Important Information about this Authorization to Release Information

Purpose: I authorize the Ventura County Health Care Plan (VCHCP) 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 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.

Section 3: Release Information

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):

_____

_____

_____

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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:	
Relationship to Patient:	Phone Number:
Street Address:	
City:	Zip Code:

Name:	
Relationship to Patient:	Phone Number:
Street Address:	
City:	Zip Code:

Name:	
Relationship to Patient:	Phone Number:
Street Address:	
City:	Zip Code:

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

*Any authorization concerning a minor under the age of twelve will automatically expire upon the minor's twelfth 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 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 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 submit the original to VCHCP.

Mail: **VCHCP**
Attn: Member Services
2220 E. Gonzales Road, Suite 210B
Oxnard, CA 93036

Fax: **(805) 981-5051**

Email: **VCHCP.Memberservices@ventura.org**