



RELEASE OF INFORMATION FORM

This form is used to **AUTHORIZE RELEASE OF HEALTH INFORMATION**. It is to allow a Member or Representative who has already been appointed, to authorize disclosure of health information to Contra Costa Health Plan.

If you have any questions, please call the Member Services Department at 1-877-661-6230 (Press 2) (California Relay/TTY/TDD only, call 1-800-735-2929).

Please mail the completed form to: Contra Costa Health Plan, Member Services Department, 595 Center Avenue, suite 100, Martinez, CA 94553, **or fax it to 925-313-6047** or email it to us at member.services@hsd.cccounty.us

MEMBER OR REPRESENTATIVE'S AUTHORIZATION TO DISCLOSE HEALTH INFORMATION		
Name of Member: (First, Middle, Last, Title)	Member ID Number:	
Name of Representative (if applicable): (First, Middle, Last Title)		
Member's Address: (including zip code)	Member's Date of Birth: (Month/Day/Year)	
Member's Home Telephone Number: (including area code)	Member's Daytime Telephone Number: (including area code)	Member's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
I am the <input type="checkbox"/> Member <input type="checkbox"/> Guardian <input type="checkbox"/> Conservator <input type="checkbox"/> Designee:		
I hereby authorize Contra Costa Health Plan to use or disclose health information of the above named individual to:		
Name of Individual, Agency or Organization	Telephone Number:	
Address: (including zip code)		



Purpose of Disclosure: <input type="checkbox"/> At the Request of the Individual	Dates and Types of Information to be Disclosed:	
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REDISCLOSURE:

If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected. California law and a federal law governing drug abuse patient records prohibits recipients of your health information from re-disclosing such information, except with your written authorization or as specifically required or permitted by law.

INFORMATION TO BE DISCLOSED:

This is a FULL disclosure authorization of health care information which includes health care maintenance records, and medical, surgical, sexually-transmitted disease, mental health, alcohol or other drug abuse care and treatment records, if any. This consent also authorizes the disclosure of HIV test results, if any. These records will be disclosed unless specifically excluded below:

(INITIAL) ____ NO EXCLUSIONS

- EXCLUDE: (INITIAL) ____ Exclude HIV test results
 (INITIAL) ____ Exclude Substance Abuse treatment information
 (INITIAL) ____ Exclude Mental Health treatment information
 (INITIAL) ____ Exclude other: _____

This authorization is effective immediately and will remain in effect for one year or until _____(date), whichever comes first. I may revoke this authorization at any time; My revocation must be in writing, signed by me or on my behalf, and delivered to Contra Costa Health Plan. My revocation will be effective upon receipt, but will not be effective to the extent that Contra Costa Health Plan has acted in reliance upon this Authorization. I have a right to receive a copy of this Authorization. If I am being asked by Contra Costa Health Plan to authorize this disclosure, I have a right to inspect or obtain a copy of such health information disclosed. I may refuse to sign this Authorization. Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this Authorization.

Member's signature:	Date
Representative's signature:	Date