Authorization for Disclosure of Health Information [Please Print]

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows the Health Plan (your health insurance carrier or HMO) to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to the Health Plan (contact Member Services for further instructions). Revoking this authorization will not affect any action taken prior to receipt of your written request.

Section A. Member Information: (individual whose information will be released)

Name: (First, Middle, Last, Title)	**Member ID Number:**	**Date of Birth:** (Month/Day/Year)
Address: (including zip code)		**Telephone Number:** (including area code)

Section B. Health Plan: (organization that will release your information)

I authorize _____ to release my protected health information as described below.
(Health Plan name on your ID card)

Section C. Recipient: (person or organization that will receive your information)

Person's Name or Organization:	**Telephone Number:** (including area code)
Address: (including zip code)	**Fax Number:** (if available)

Section D. Description of the Information to be Released: (what type of information will be released)

Check ONLY ONE box:

☐ **Psychotherapy notes** – Federal law requires a separate authorization to use or release psychotherapy notes.
If you check this box, you may not check another box below.

☐ **All information related to the provision of and payment for my health care benefits or services.***

☐ **Specific information as described on the line below:***

_____
Examples: The claim related to my service on (date); Appeal information related to my claim on (date)

***NOTE**: State law requires that you give specific permission to release the information below even if you checked a box above. Indicate your permission for the Health Plan to release any of the following information by initialing all that apply.

Genetic Information _____ (Initials) **HIV/AIDS** _____ (Initials)
Substance/Alcohol Abuse _____ (Initials) **Mental/Behavioral Health** _____ (Initials)

Purpose of Release: _____
Examples: At my request; To resolve my appeal; To assist with my health insurance services

Section E. Expiration: (when this authorization will end)**

This authorization will expire (Check ONLY ONE box):

☐ **When I revoke this authorization***

☐ **Upon the following date, event or condition*:** _____

*** The party identified in Section B must be notified in writing of the event/condition to cancel or revoke this authorization.**

Section F. Approval: (You OR your Personal Representative must sign and date this form in order for it to be complete.)

I understand that this authorization to release information is voluntary and is not a condition of enrollment in this Health Plan, eligibility for benefits, or payment of claims. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws.

Member Signature: By signing below, I authorize the release of my protected health information as described above.	**Personal Representative Information:** A Personal Representative is a person who has the legal authority to act on behalf of an individual. A copy of a Power of Attorney or other legal document must be on file at the Health Plan or submitted with this form.
_____ (Print Name) _____ (Signature of Member) _____ (Date)	_____ (Printed Name of Personal Representative) _____ (Description of Representative's Authority) _____ (Date) _____ (Signature of Personal Representative) (____)_____ (Telephone Number)

PLEASE KEEP A COPY OF THIS FORM AND THE INSTRUCTIONS FOR YOUR RECORDS 08161 (11/16)

Instructions - Authorization for Disclosure of Health Information

This form is used for you or your Personal Representative to authorize the Health Plan to release your protected health information to another person or organization at your request.

"Protected health information," means individually identifiable health information. It is information about you, including your name, address and medical information and may relate to your past, present or future physical or mental health or condition. The Health Plan maintains information that may include eligibility, benefits, claims or payment information.

Section A. Member Information: (individual whose information will be released)

Print your complete name, member ID number, address, date-of-birth and telephone number.

Important: Provide the Member ID Number located on the front of your Health Plan identification card. Be sure to include any letters in front of the identification number.

Section B. Health Plan: (organization that will release your information)

The Health Plan is your insurance carrier or HMO that maintains information about you. Print the name of your Health Plan on the line provided.

Section C. Recipient: (person or organization that will receive your information)

The recipient is a person or organization that you choose to receive your protected health information from the Health Plan. You must provide all of the contact information in order for the information to be released.

- Identify the person, family member or organization to receive your information.
- Provide the contact information about the person, family member or organization to receive your information.

Section D. Description of the Information to be Released: (what type of information will be released)

You must indicate or describe the information to be released. **Check ONLY ONE box that best describes your request**. There are three choices. The first choice is **Psychotherapy Notes**. The second choice is **All Information**. The third choice is **Specific Information** that you must describe on the line provided. **CHECK ONLY ONE BOX.**

If this authorization is to release psychotherapy notes, the Health Plan cannot release any other information unless you complete another Authorization to Release Information form.

- **Psychotherapy Notes** are notes recorded by a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session. These notes are separated from the rest of the individual's medical record. **Psychotherapy notes cannot be combined with an authorization to release any other type of information.**
- **All Information.** If you check this box, the Health Plan may release all information related to the provision of a payment for your health care benefits or services. If someone is directly involved in coordinating your health care or benefits, you may want them to have access to all of your information.
- **Specific Information.** By checking this box, you indicate that you want only specific information to be released. Describe the specific information on the line provided.

Purpose of Release. Provide a brief description of the reason you want this information released. The statement, "At my request" is sufficient.

IMPORTANT: State law requires that you give specific permission to release certain health information. Your initials are required on each line in order for the Health Plan to release information for HIV/AIDS, Substance/Alcohol Abuse, Genetic information or Mental/Behavioral Health information.

Section E. Expiration: (when this authorization will end)

Print either an expiration date OR event, but not both. If an expiration event is used, the event must relate to the purpose of the release of information being authorized.

Section F. Approval: (You OR your Personal Representative must sign and date this form in order for it to be complete.)

Member Signature.	**Personal Representative Information.**
If you are the individual whose information will be released, you must sign and date in this section.	If you are the Personal Representative, the member's signature is not required. However, you must provide the requested information, signature and date. A copy of the legal authority, such as a Power of Attorney or other legal document, must be on file at the Health Plan or be submitted with this form.

Authorization for Disclosure of Health Information

The enclosed Authorization form is required in order to allow your Health Plan to release protected health information to another person or organization. Please review and complete the form. A number of important points are highlighted here. For more detailed instructions please refer to the instructions on the back of the Authorization Form. If you have any questions, please contact the Member Services department at the number listed on the back of your member identification card.

Each section of the form must be completed; missing information will result in delays in processing the authorization.

- ❑ Include your Member Identification Number.
- ❑ List in the "Recipient" section the name of the person or organization to whom you are authorizing your Health Plan to release information. Be sure to include the recipient's contact information such as telephone number, fax number or address.
- ❑ Review the "Description of the Information to be Released" section before completing.
- ✓ You should only check **one** of the three boxes listed.
- ✓ If you select the "Psychotherapy Notes" box, you cannot check any other box.
- ✓ If someone routinely assists you with your health care, for example, husband, wife, son or daughter, you may want to give that person access to all your information. To do this check the second box in this section and initial any/all applicable areas in the "Notes" section.
- ✓ Check the "Specific Information" box if an individual is assisting you in resolving a particular issue such as an appeal, list the specific information on the line below the box and initial any/all applicable areas in the "Notes" section.
- ✓ A "Purpose of Release" should also be noted.
- ❑ An "Expiration" must be listed. You can allow the authorization to remain in effect until you revoke it in writing. You may also indicate that the authorization will expire on a specific date or at the conclusion of an event, such as an appeal.
- ❑ You or your Personal Representative must sign the authorization. Only one signature is required. If a Personal Representative signs the authorization, a copy of the legal documents showing they have authority to act on the member's behalf must be on file at the Health Plan or submitted with the authorization.
- ❑ Return the completed authorization form to the following address:

Member Correspondence
P O Box 41890
Philadelphia, PA 19101-1890
Fax Number: 215-241-2042 or 1-888-457-3013 (Toll Free)

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કૉલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں. کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.