Keystone
VIP CHOICE
COVERAGE BY VISTA HEALTH PLAN, INC.
Independent Licensee of the
Blue Cross and Blue Shield Association

Keystone VIP Choice HIPAA Release of Information Form

This form will be used to confirm a Member's permission that Keystone VIP Choice may discuss or disclose Protected Health Information (PHI) to a particular person who acts as the Member's Personal Representative. Use of the PHI is strictly limited to this purpose.

Section A-Member Information

Member's Name: _____

Date of Birth: _____ Member ID: _____

Address: _____

Telephone Number: _____

Section B-Scope of Information

Information Authorized for Use or Disclosure: (please check all boxes that apply or specify if not listed)

☐ Premium information and eligibility status

☐ Claims history

☐ Prescription Drug history

☐ Identification of treating providers care, diagnoses and procedures (Please note: This information may include diagnoses and/or treatment for alcohol and/or drug abuse; AIDS/AIDS Related Complex (ARC) and HIV diagnoses and/or treatment; and diagnoses and/or treatment relating to other communicable disease subject to any applicable state law restrictions)

☐ Primary Care Physician changes/updates

☐ Demographic changes/updates

☐ Psychotherapy notes

☐ Authorizations or Referrals on file

☐ Other (please specify): _____

☐ All items listed above

Section C-Authorized Use and/or Disclosure

Intended Use or Disclosure

I understand that Keystone VIP Choice's general policy is not to disclose my personal health information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my PHI, as described in Section B, to the person(s) named below. I also understand that if my Personal Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, those privacy laws may no longer protect my PHI and my Personal Representative (if applicable) may disclose my PHI without my authorization. I acknowledge that my authorization is voluntary.

Personal Representative

Name: _____

Address: _____

Relationship to you: _____ Telephone Number _____

Section D-Expiration and Revocation

This authorization to release information to my Personal Representative will automatically expire two (2) years following the termination of my enrollment with Keystone VIP Choice.

I understand that I have the right to revoke or end this authorization at any time. I understand that, if I do not wish the person names in Section C to remain my Personal Representative, I must revoke this authorization in writing by giving written notice of my decision to Keystone VIP Choice. I may call Member Services and request a Revocation of Authorization Form to assist me in submitting my written request. In addition, I understand that this revocation will not revoke any other authorizations to release information that I have provided to Keystone VIP Choice. Revocation of this authorization will not affect any action that Keystone VIP Choice has taken, or any PHI that Keystone VIP Choice has already released, based upon this authorization before the Health Plan has actually received my request to revoke it.

Section E-Signature/Authorization

I have had full opportunity to read and consider the content of this Keystone VIP Choice HIPAA Release of Information Form. I confirm that this authorization is consistent with my request of the Keystone VIP Choice. I understand that, by signing this form, I am confirming my authorization that the Keystone VIP Choice may use and/or disclose my PHI to the person named in Section C for the purpose described above. I also confirm that a faxed copy of this form is acceptable.

Member or Legal Representative Signature: _____

Member or Legal Representative Printed Name: _____

Date Signed: _____

You may mail or fax the completed form to:

Keystone VIP Choice Enrollment
PO Box 851677
Richardson, TX 75085-1677

Fax Number: 855-822-9400