AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

(INSTRUCTIONS AND IMPORTANT INFORMATION ON REVERSE)

1

Please PRINT your name (the Health Plan member) and other information requested below.

Member Name:	Date of Birth:
Address:	
Member ID#:	Telephone: ( )
I authorize _____ ** **(Print name of Health Plan on identification card)**	to release my PHI as indicated below to the person(s)/entity(s) named in Part 2.

2

Please PRINT the name(s) of the Authorized Person(s) to whom the Health Plan may release your PHI.

Name:	Relationship:
Address:	Telephone: ( )
Name:	Relationship:
Address:	Telephone: ( )
Name:	Relationship:
Address:	Telephone: ( )

3

What PHI may the Health Plan release to the Authorized Person(s)?

____ **Any** information or PHI in connection with any claim or appeal for coverage or benefits, **including but not limited to:**

- Benefits, premiums, eligibility, deductibles, etc.
- Address or telephone number, date of birth, etc.
- Medical records, hospital/prescription pre-authorizations, referrals, etc.

____ Other/special instructions: _____

4

What actions may the Authorized Person(s) take in regard to your PHI checked in Part 3?

_X_ The Authorized Person(s) may **discuss** my PHI in person, writing or via phone.

____ The Authorized Person(s) may **discuss and receive copies** of my PHI (e.g. explanation of benefits, etc.).

____ The Authorized Person(s) may **discuss, receive copies of, and make changes to** my PHI (e.g. PCP changes, address changes, etc.).

____ The Authorized Person(s) may do **anything** I am permitted to do.

5

By signing below, I understand I am authorizing the use/release of my PHI and:

1. My authorization is voluntary and not a condition of enrollment, eligibility, or claim payment;
2. The Authorized Person(s) may not be subject to federal/state privacy laws and they may further release my PHI;
3. I may revoke this authorization at any time by sending written notice, however, revocation will not affect any action previously taken in reliance on this authorization **prior** to the Health Plan's receipt of my revocation;
4. This authorization **replaces** any HIPAA authorizations previously sent to the Health Plan, unless checked here _____
5. This authorization **will expire** in (**check one**): ___ one (1) year ___ three (3) years ___ five (5) years from the date received by the Health Plan **OR** on expiration of the following (e.g. litigation): _____

See reverse for important information regarding expiration date and previously submitted authorizations.

6

MEMBER OR PERSONAL REPRESENTATIVE SIGNATURE:

Print Name:	Relationship:
Signature:	Date:

WHY WE ARE ASKING FOR YOUR AUTHORIZATION

The Health Insurance Portability and Accountability Act (HIPAA), effective April 14, 2003, requires your express permission before we may discuss/release your protected health information (PHI) to your relatives, friends, employer, etc. This authorization is needed to document your intent and to identify the person(s) who have your permission to contact us on your behalf ("authorized person") for claims status, benefit information, and/or other matters pertaining to your insurance coverage.

In most instances, HIPAA does not require your authorization before we may share your PHI with health care providers (e.g. physicians, hospitals, etc.) involved in your treatment or payment for your treatment. This exception is to ensure uninterrupted business operations such as timely submission and processing of your claims for medical benefits. *Therefore, it is NOT necessary to name your health care providers as authorized persons.*

HOW TO USE/COMPLETE THIS AUTHORIZATION

- **Sensitive information/diagnoses**
  Do NOT use this form to request the release of *HIV/AIDS information, mental health, and alcohol or substance abuse information.* The required forms are 2(D) and 2(E) respectively, which are available on-line or by contacting Customer Service.
  If you are using this form to authorize the release of *psychotherapy notes*, it must ONLY be used for psychotherapy notes. You MUST use a separate 2A form to authorize the release of any other PHI.

- **PART 1:**
  This section should name the *member of the Health Plan* whose PHI will be shared with and/or disclosed to the authorized person(s).

- **PART 2:**
  This section should name the authorized person(s), such as a spouse or child, who will be contacting the Health Plan to discuss the member's PHI.

- **PART 3:**
  This section should indicate the specific PHI of the member that the Health Plan may share with and/or disclose to the authorized person(s).

- **PART 4:**
  This section is to identify how much authority you are giving the authorized person(s) to access and/or change your PHI. The default selection is marked with an 'X'. Mark any additional selections that apply.

- **PART 5:**
  Read this section carefully. Signing this form attests to all statements made in this section. **IMPORTANT:** (a) If the information is to be **added** to an authorization previously sent to the Health Plan, a checkmark **must** be made otherwise all previous information will be voided; (b) An 'indefinite', 'ongoing' or 'non-expiring' authorization will not be considered valid. This authorization will expire one (1) year from the date it is received if an expiration date is not specified.

- **PART 6:**
  The *member's* signature is required. If the member is incapable of signing due to illness, injury or death, a personal representative (see below) may sign on the member's behalf.
  A personal representative (PR) such as the parent of a minor child, power of attorney or executor, may sign his or her name in the member's stead. The legal documents proving the authority of the PR to act for the member MUST be attached otherwise the PR's signature and this authorization will NOT be honored.

- **Complete ALL sections**
  This authorization will ONLY be considered valid if ALL sections are fully completed.

CONTACT INFORMATION

PLEASE RETURN YOUR AUTHORIZATION FORM(S) TO THE ADDRESS LISTED BELOW

If you have any questions or need assistance in completing this form, please call the Customer Service telephone number on the back of your identification card or write to:

Privacy Department
PO Box 15013, Albany, NY 12212

Privacy Department
PO Box 80, Buffalo, NY 14240