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.

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).

NOTA: For the release of sensitive information (e.g. HIV/AIDS, drug and alcohol, mental health, genetic testing), you must check the box(es) that apply to you.

Return the Completed Form to:
Member Correspondence
P.O. Box 41890 • Philadelphia, PA 19101-1890
Fax Number: 215-241-2042 or 1-888-457-3013 (Toll Free)

Please keep a copy of this form and the instructions for your records.

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Instructions for Completing the Authorization to Disclose Health Information Form

If you have any questions, please feel free to call us at the customer service number on your member identification card.

Please read the following for help completing page two of the form.

PART E: Purpose of this Approval - This section tells us the reason you’ve asked for the release of your information.
1. Check the first box if you are appealing a denied claim, a denied preauthorization, or your cost share.
2. Check the second box for a specific reason. An example might be to resolve an appeal.

PART F: Expiration Date of this Approval – This section tells us when you want this authorization to expire.
3. Check the first box if you want the authorization to expire when you specifically write to us and revoke it.
4. Check the second box if you want the authorization to expire on a specific date or event/condition (for example, when my appeal is resolved) and fill in the date, event, or condition.

Part G. Approval

1. Sign and print your name and put the date on the form. Your name and signature must match the information in Part A.
2. If you are signing this form on behalf of another person, or if you have Power of Attorney for health care, or are a legal guardian/conservator you must do the following:
   - Complete the Personal Representative Information section.
   - You must also provide us with a copy of the legal document showing that you are considered the personal representative of the member and include the document with this form.

Examples of legal documents:
- General or Durable Power of Attorney. This document gives someone the legal power to act on your behalf and make health care decisions for you.
- Legal Guardianship. This is when the court appoints someone to care for another person.
- Conservatorship. This happens when a judge appoints a responsible person to make decisions for someone who can’t make responsible decisions for him/herself.
- Executor of estate or death certificate. This type of document would be used when the person who is being represented has died.

Authorization for Disclosure of Health Information

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.

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

- Member First Name, Middle Initial and Last Name: __________________________
- Member Date of Birth: __________
- Member Street Address: __________________________
- City State Zip Code: __________________________
- Member Date of Birth: __________
- Daytime Telephone Number (with area code): __________________________

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

- I authorize __________________________ to release my protected health information as described below.

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

- The following individual or company has the right to receive my information (they must be 18 years of age or older).

Part D. Description of the Information to be Released:

- I allow the following information to be used or released on my behalf: (CHECK ONLY ONE BOX):
  - Psychotherapy Notes. Federal law requires a separate authorization to use or release psychotherapy notes.
  - All My Information. This can include health, diagnosis (name of illness or condition), claims, doctors and other health care providers and certain financial information (such as premium billing and payment). This does not include sensitive information (see below) unless it is approved below.

- OR
  - Only Limited Information may be released (check all boxes below that apply to you):
    - Appeal information
    - Benefits and coverage
    - Premium billing and payment
    - Claims and payment
    - Diagnosis (name of illness or condition) and procedure (treatment)

- I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time by providing written notice to my health plan, or as described below in Part F. I understand that I cannot cancel this approval when this form has already been used to disclose information.

PLEASE KEEP A COPY OF THIS FORM AND THE INSTRUCTIONS FOR YOUR RECORDS

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