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 one of the form.

1 CHECK THIS BOX IF YOU ARE APPEALING A DENIED CLAIM, A DENIED PREAUTHORIZATION, OR YOUR COST SHARE.

PART A: Member Information

This section applies to the member who is asking for the release of his or her information to another person or company.

2 Print your first name, middle initial and last name.

3 Write your Identification number - You will find this number on your member identification card.

4 Write your full street address, city, state, and zip code.

5 Write your date of birth.

6 Write your daytime phone number (including area code).

PART B: Health Plan that will release your information

7 Print the name of your Health Plan that provides your health insurance coverage.

PART C: Recipient - Person or organization that will receive your information

8 Write the full name, address, telephone number and relationship to you of the person or company that you want us to give your information to. Please don't use a general term like "my daughter" or "my son" as it will not be accepted. You need to be specific.

The individual that you designate to receive your information must be 18 years or older. If the individual is an emancipated minor, legal documentation of emancipation must be provided to your Health Plan before your information will be released to the minor.

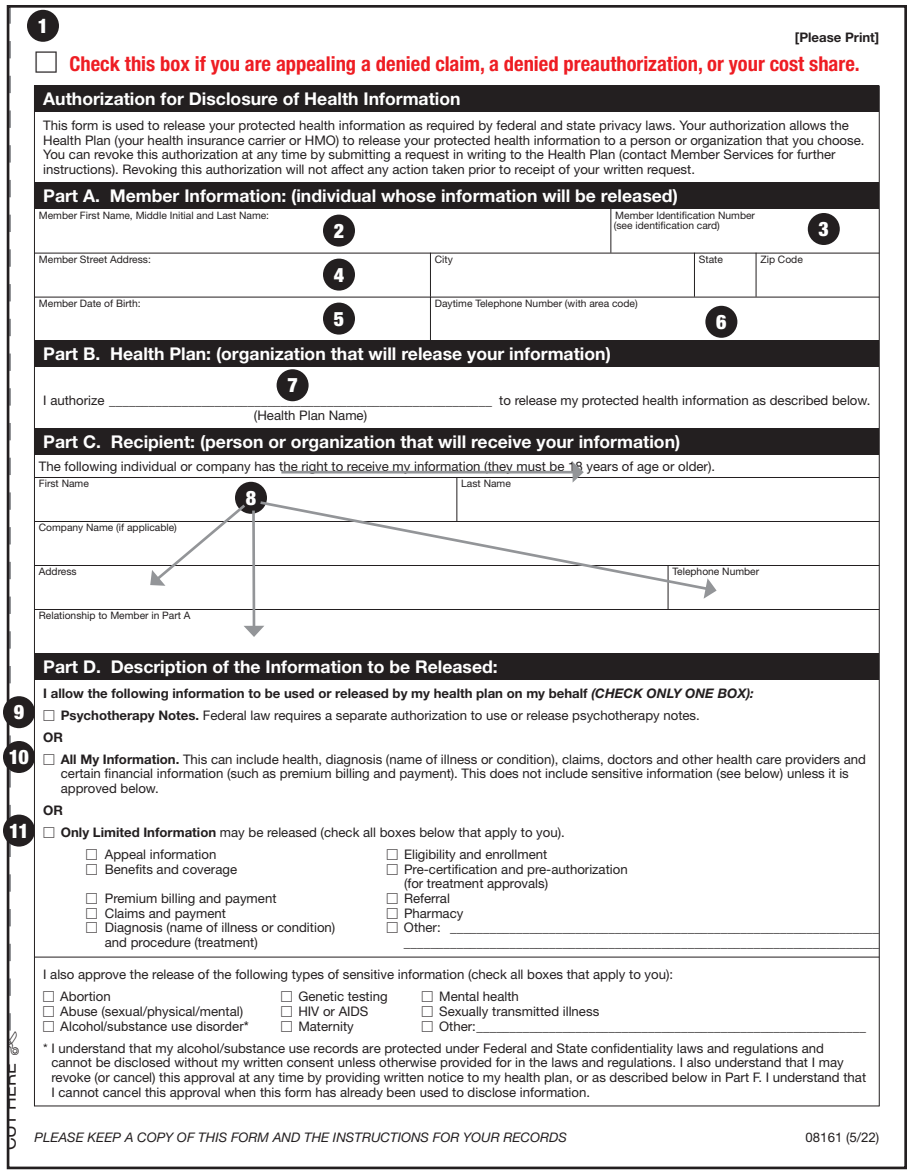
PART D: Description of the Information to be Released - This section tells us what information you would like us to release: all or just some.

9 For only "psychotherapy notes" check the first box.

10 For "all of your information" check the second box.

11 For "only limited information" check the box(es) that apply to you.

NOTE: 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.



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☐ Check this box if you are appealing a denied claim, a denied preauthorization, or your cost share.

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: 2

Member Identification Number (see identification card) 3

Member Street Address: 4

City | State | Zip Code

Member Date of Birth: 5

Daytime Telephone Number (with area code) 6

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

I authorize 7 _____ to release my protected health information as described below.
(Health Plan Name)

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).

First Name | Last Name

8

Company Name (if applicable)

Address | Telephone Number

Relationship to Member in Part A

Part D. Description of the Information to be Released:

I allow the following information to be used or released by my health plan on my behalf *(CHECK ONLY ONE BOX):*

9 ☐ **Psychotherapy Notes.** Federal law requires a separate authorization to use or release psychotherapy notes.

OR

10 ☐ **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

11 ☐ **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)
☐ Eligibility and enrollment
☐ Pre-certification and pre-authorization (for treatment approvals)
☐ Referral
☐ Pharmacy
☐ Other: _____

I also approve the release of the following types of sensitive information (check all boxes that apply to you):

☐ Abortion
☐ Abuse (sexual/physical/mental)
☐ Alcohol/substance use disorder*
☐ Genetic testing
☐ HIV or AIDS
☐ Maternity
☐ Mental health
☐ Sexually transmitted illness
☐ Other: _____

* I understand that my alcohol/substance use 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.

CUT HERE ✂

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.

12 Check the first box to let us know to give out this information as shown on this form.

13 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.

14 Check the first box if you want the authorization to expire when you specifically write to us and revoke it.

15 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

16 **Sign and print your name and put the date on the form.** Your name and signature must match the information in Part A.

17 **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:**

You must 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.

Part E. Purpose of this Approval

12 ☐ To release information as described on this form

OR

13 ☐ For the following reason: _____

Part F. Expiration Date of this Approval

This authorization will expire *(Check ONLY ONE box):*

14 ☐ When I revoke this authorization*

OR

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

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

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

I understand that this authorization for disclosure of health 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.

(Signature of Member) 16

(Print Name) | (Date)

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.

(Printed Name of Personal Representative) | (Description of Representative's Authority) 17

(Date) | (Signature of Personal Representative) | (Telephone Number)

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)

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).

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。

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.

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☐ **Check this box if you are appealing a denied claim, a denied preauthorization, or your cost share.**

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 Identification Number (see identification card)	
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.
(Health Plan Name)

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).

First Name	Last Name
Company Name (if applicable)	
Address	Telephone Number
Relationship to Member in Part A	

Part D. Description of the Information to be Released:

I allow the following information to be used or released by my health plan on my behalf *(CHECK ONLY ONE BOX):*

☐ **Psychotherapy Notes.** Federal law requires a separate authorization to use or release psychotherapy notes.

OR

☐ **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)
- ☐ Eligibility and enrollment
- ☐ Pre-certification and pre-authorization (for treatment approvals)
- ☐ Referral
- ☐ Pharmacy
- ☐ Other: _____

I also approve the release of the following types of sensitive information (check all boxes that apply to you):

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Alcohol/substance use disorder*
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Other: _____

* I understand that my alcohol/substance use 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.

CUT HERE

Part E. Purpose of this Approval

☐ To release information as described on this form

OR

☐ For the following reason: _____

Part F. Expiration Date of this Approval

This authorization will expire *(Check ONLY ONE box):*

☐ When I revoke this authorization*

OR

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

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

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

I understand that this authorization for disclosure of health 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.

(Signature of Member)	
(Print Name)	(Date)

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.

(Printed Name of Personal Representative)	(Description of Representative's Authority)	
(Date)	(Signature of Personal Representative)	(Telephone Number)

Return the Completed Form to:

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P O Box 41890 • Philadelphia, PA 19101-1890
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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).

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。

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al número telefónico de Servicio al Cliente que figura en el reverso de su tarjeta de identificación.

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。请致电您ID卡背面的客户服务电话号码.

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드 뒷면에 있는 고객 서비스 번호로 전화해 주십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para telefone do Atendimento ao Cliente que está no verso do seu cartão de identificação.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. કૃપયા તમારા આઇડી કાર્ડની પાછળ ગ્રાહક સેવા નંબર પર કોલ 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 số Dịch Vụ Chăm Sóc Khách Hàng ở mặt sau thẻ ID của bạn.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Позвоните в службу поддержки клиентов по номеру телефона, указанном на обратной стороне вашей идентификационной карты.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer Obsługi klienta znajdujący się na odwrocie Twojego identyfikatora.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiami il numero dell'Assistenza clienti che troverà sul retro della sua tessera identificativa.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. الرجاء الاتصال برقم "خدمة العملاء" الموجود على ظهر بطاقة هويتك.

French Creole: ATANSYON : Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Tanpri rele nimewo Sèvis Kliyantèl ki sou do kat idantifikasyon ou a.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Mangyaring tawagan ang numero ng Customer Service na nasa likod ng iyong ID card.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Veuillez composer le numéro du service clientèle indiqué au dos de votre carte d'identité Médicale.

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 Number uff die hinnerscht Seit vun dei ID Card uff fer schwetze mit ebber as dich helfe kann.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कृपया अपने आईडी कार्ड के पीछे दिए ग्राहक सेवा नंबर पर कॉल करें।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Bitte rufen Sie unsere Kundendienstnummer auf der Rückseite Ihrer Identifikationskarte an.

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。ご自分のIDカードの裏面に記載されているカスタマーサービスの番号へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی شما درج شده است تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. T'áá shǫǫdí hódíílnih kojį' Áká'anídaalwo'jį éí binumber naaltsoos nitł'izgo nantinígíí bine'dęę' bikáá'.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ آپ کے شناختی کارڈ کے پیچھے دئیےگئے صارف خدمات نمبر پر برائے کرم کال کریں.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរសព្ទទៅលេខសេវាសមាជិក ដែលមាននៅផ្នែកខាងក្រោយនៃបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក ។

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*.