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: 如果您懂中文, 您可以得到免费的语言协助服务。致电1-800-275-2583。
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 you the reason you’ve asked for the release of your information.

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

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

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

6. 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.

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 Social Security Number: __________________________

Member Date of Birth: __________________________

Daytime Telephone Number (with area code): __________________________

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

Health Plan Name: __________________________

Address: __________________________

City, State, Zip Code: __________________________

Fax Number: __________________________

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).

Recipient Name: __________________________

Address: __________________________

Fax Number: __________________________

Company Name (if applicable): __________________________

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 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

☐ Pre-certification and pre-authorization (for treatment approvals)

☐ Eligibility and enrollment

☐ Referral

☐ Pharmacy

☐ Other:

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

☐ Abortion

☐ Genetic testing

☐ Alcohol/substance abuse

☐ Mental health

☐ Abuse (sexual/physical/mental)

☐ HIV or AIDS

☐ Sexually transmitted illness

☐ Maternity

☐ Other:

All information on this form is for the sole purpose of releasing 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.

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

08161 (7/17)
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.

- Check the first box if you want to authorize us to provide this information to another person or organization.
- Check the second box if you want the authorization to expire on a specific date, event or condition.
- Check the third box if you are signing this form on behalf of another person.

PART F: Expiration Date of this Approval – This section tells us when you want this authorization to expire.

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

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

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 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 themselves.
- **Executor of estate or death certificate.** This type of document would be used when the person who is being represented has died.

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

<table>
<thead>
<tr>
<th>Member First Name, Middle Initial and Last Name:</th>
<th>Member Identification Number (see identification card)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Member Date of Birth:</th>
<th>Member Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Member Street Address:</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Member Date of Birth:</th>
<th>Daytime Telephone Number (with area code)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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).

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Company Name (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.
- [ ] 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
  - [ ] Diagnoses (name of illness or condition) and procedure (treatment)
  - [ ] Eligibility and enrollment
  - [ ] Pre-certification and pre-authorization (for treatment approvals)
  - [ ] Referral
  - [ ] 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/AIDS
- [ ] Mental health
- [ ] Sexually transmitted illness
- [ ] Maternity
- [ ] 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.

08161 (5/22)
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)
(Printed Name of Personal Representative)

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)

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)

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.

☐ Print your first name, middle initial and last name.
☐ Write your Identification number - You will find this number on your member identification card.
☐ Write your full street address, city, state, and zip code.
☐ Write your date of birth.
☐ Write your daytime phone number (including area code).

Part B: Health Plan that will release your information
Print the name of your Health Plan that provides your health insurance coverage.

Part C: Recipient - Person or organization that will receive your information
Write the full name, address, telephone number and relationship to you of the person or company that you want 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.

☐ For only “psychotherapy notes” check the first box.
☐ For all of your information check the second box.
☐ 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.

Please keep a copy of this form and the instructions for your records.
BRN (1/15)
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: તમારો ગુજરાતી બોલતા હો, તો નિજનું લાભ સહકર સેવાએ તમારા માટે ઉપલબ્ધ છે. કિંમત તમારા આખી કિંમતી પાછળ ગ્રાહક સેવા નંબર પર કોલ કરો.


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


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: ملاحظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجمل. الرجاء الاتصال برقم "خدمة العملاء" الموجود على ظهر بطاقة هوتيك.


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.


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 गए ग्राहक सेवा नंबर पर कॉल करें।


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 می‌کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می‌باشد. لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی شما درج شده است تماس بگیرید.
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.