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.

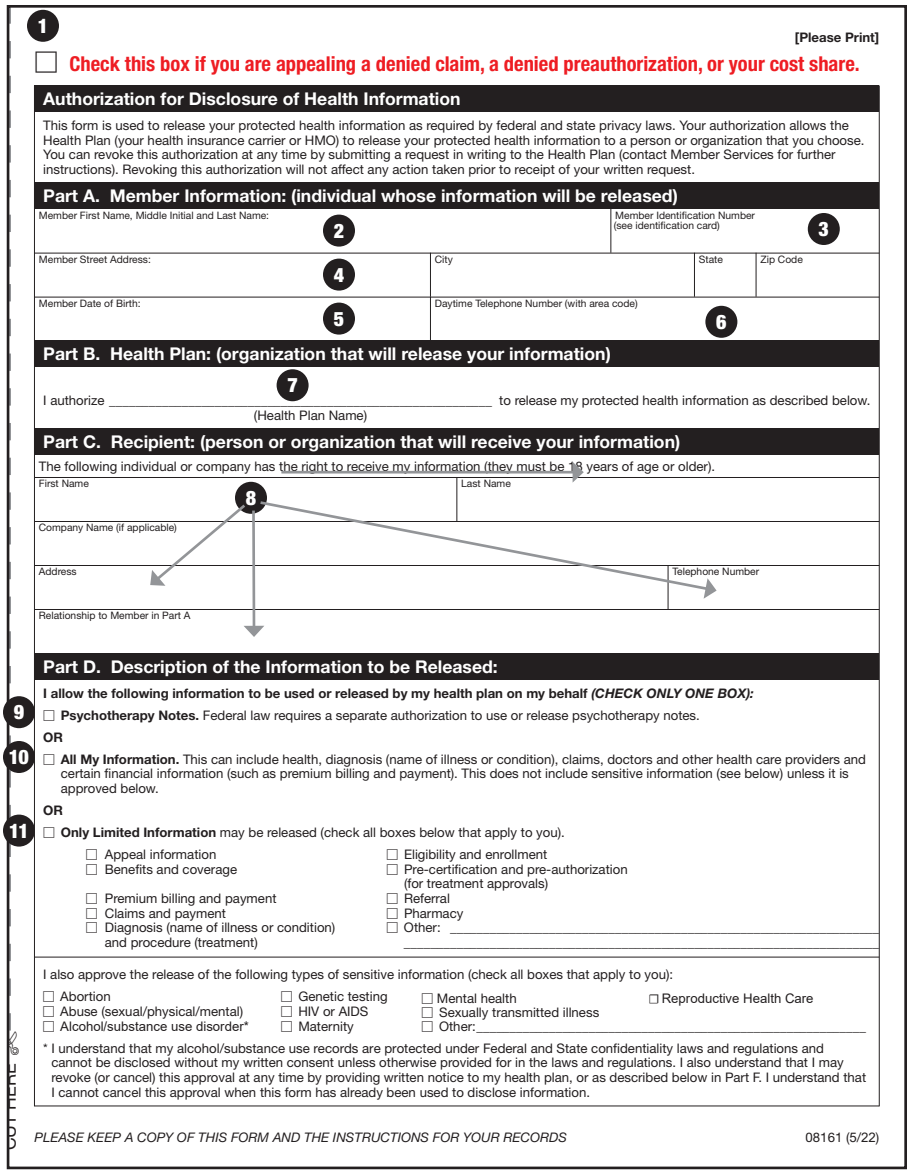
PART D: Description of the Information to be Released - This section tells us what information you would like us to release: all or just some.

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

Company Name (if applicable) 8

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: _____
☐ Reproductive Health Care

* 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.

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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):

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- ☐ Alcohol/substance use disorder*
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Other: _____
- ☐ Reproductive Health Care

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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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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。

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-275-2583 (TTY: 711) or speak to your provider.

العربية: انتباه: إذا كنت تتحدث العربية، فيمكنك الحصول على مساعدة لغوية مجانية. كما تتوفر الوسائل والخدمات المساعدة والمناسبة مجانًا لضمان وصول المعلومات إليك بصيغ ميسّرة ومناسبة. يُرجى الاتصال على الرقم 1-800-275-2583 (TTY: 711) أو يمكنك التحدث مع مقدم الرعاية الخاص بك.

বাংলা: দৃষ্টি আকর্ষণ: যদি আপনি বাংলাভাষী হন, তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা উপলব্ধ। অ্যাক্সেসিবল ফরম্যাটে তথ্য প্রদান করার জন্য উপযুক্ত সহায়ক উপকরণ ও পরিষেবা বিনামূল্যে উপলব্ধ। 1-800-275-2583 (TTY: 711) নম্বরে কল করুন বা আপনার প্রদানকারীর সঙ্গে যোগাযোগ করুন।

普通话: 注意：如果您说普通话，我们将为您免费提供语言协助服务。我们还免费提供适当的辅助工具和服务，确保以无障碍格式传递信息。请致电 1-800-275-2583（TTY：711）或咨询服务提供者。

Français: ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services supplémentaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-275-2583 (TTY: 711) ou parlez-en à votre fournisseur.

Kreyòl Ayisyen: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis asistans pou lang ki disponib pou ou. Gen èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòma aksesib ki disponib tou gratis. Rele nan 1-800-275-2583 (TTY: 711) oswa pale ak founisè w la.

ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારી માટે મફત ભાષા સહાયતા સેવા ઉપલબ્ધ છે. સુલભ સ્વરૂપમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનો અને સેવાઓ પણ મફતમાં ઉપલબ્ધ છે. 1-800-275-2583 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતાનો સંપર્ક કરો.

हिंदी: ध्यान दें: अगर आप हिंदी बोलते हैं, तो आपके लिए भाषा संबंधी सहायता सेवाएँ मुफ़्त में उपलब्ध हैं। सुलभ फ़ॉर्मेट में जानकारी प्रदान करने के लिए उचित सहायक सहायता और सेवाएँ भी मुफ़्त में मिलती हैं। 1-800-275-2583 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Italiano: ATTENZIONE: Se parli Italiano, puoi trovare disponibili servizi gratuiti di assistenza linguistica. Gratuitamente, sono inoltre disponibili ausili e servizi di supporto adeguati per fornire informazioni in formati accessibili. Chiama il numero 1-800-275-2583 (TTY: 711) oppure rivolgiti al tuo fornitore.

日本語: 注意: 日本語話者の方には、無料の言語支援サービスをご提供しています。アクセシビリティ情報を提供するための適切な補助やサービスも無料でご利用いただけます。1-800-275-2583 (TTY: 711) にお電話くださるか、または、プロバイダーにお問い合わせください。

한국어를: 주의: 한국어를 구사하시는 경우 무료 언어 보조 서비스를 이용할 수 있습니다. 접근성 높은 형식으로 정보를 제공하기 위한 적절한 보조 도구 및 서비스 역시 무료로 이용 가능합니다. 1-800-275-2583 (TTY: 711) 에 전화하시거나 서비스 제공업체에 문의하세요.

Diné bizaad: BAA'ÁKONÍNÍZIN: Diné bizaad bee yáníłti'go, t'áá jiik'eh saad bee áka'aná'awo' bee áka'anída'awo'í ná hóló. T'áadoole'é binahjį' bee adahodooníłí diné bich'į' anídahazt'i'í bee bika'anída'awo'í beego bee baa dahane'í baa dahwiizt'i'go hadadilyaaígíí ałdó' t'áá jiik'eh hǫlǫ́. Kohjį' 1-800-275-2583 (TTY: 711) hodíilnih doodago níka'análawo'í bich'į' hanidziih.

Pennsilfaanisch-Deitsch: WICHDICH: Wann du Deitsch schwetzscht, kenne mer dich Schprooch-Hilf beigriege, unni as es dich ennich eppes koschde zellt. Mir kenne dich aa differnti Sadde Hilf beigriege, wasewwer as brauchscht fer Information griege, aa fer nix. Call 1-800-275-2583 (TTY: 711) odder schwetz mit dei Provider.

Polski: UWAGA: Jeśli jesteś osobą polskojęzyczną, pamiętaj, że oferujemy bezpłatne usługi pomocy językowej. Bezpłatnie dostępne są również odpowiednie materiały pomocnicze i usługi informacyjne w przystępnych formatach. Zadzwoń na numer 1-800-275-2583 (TTY: 711) lub porozmawiaj z dostawcą usług.

Português: ATENÇÃO: se você fala português, há serviços gratuitos de assistência linguística disponíveis. Também são disponibilizados gratuitamente para suporte e serviços auxiliares apropriados para o fornecimento de informações. Ligue para 1-800-275-2583 (TTY: 711) ou entre em contato com seu prestador.

Русский: Внимание! Если вы говорите по-русски, вам доступны бесплатные услуги переводчика. Также бесплатно предоставляются соответствующие вспомогательные услуги по предоставлению информации в доступных форматах. Звоните по телефону 1-800-275-2583 (TTY: 711) или обратитесь к своему провайдеру.

Español: ATENCIÓN: Si habla español, hay servicios gratuitos de asistencia lingüística disponibles. También hay ayudas y servicios auxiliares disponibles y sin cargo en formatos accesibles para brindarle información. Llame al 1-800-275-2583 (TTY: 711) o hable con su prestador.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, available para sa iyo ang mga libreng serbisyo sa tulong sa wika. Available din ang naaangkop na mga auxiliary aid at serbisyo para magbigay ng impormasyon sa mga naa-access na format nang walang bayad. Tumawag sa 1-800-275-2583 (TTY: 711) o makipag-usap sa iyong provider.

తెలుగు: గమనిక: మీరు తెలుగు మాట్లాడితే, ఉచిత భాష సహాయ సేవలు మీకు అందుబాటులో ఉన్నాయి. అందుబాటులో ఉన్న ఫార్మాట్‌లలో సమాచారాన్ని అందించడానికి తగిన సహాయక పరికరాలు అలాగే సేవలు కూడా ఉచితంగా లభిస్తాయి. 1-800-275-2583 (TTY: 711) నంబర్‌కు కాల్ చేయండి లేదా మీ ప్రొవైడర్‌తో మాట్లాడండి.

Українська: Увага! Якщо ви говорите українською, вам доступні безплатні послуги перекладача. Також безоплатно надаються відповідні допоміжні послуги з надання інформації в доступних форматах. Телефонуйте за номером 1-800-275-2583 (TTY: 711) або зверніться до свого провайдера.

Tiếng Việt: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Bạn cũng có thể nhận được các công cụ và dịch vụ hỗ trợ khác để giúp tiếp cận thông tin dễ dàng hơn, hoàn toàn miễn phí. Vui lòng gọi 1-800-275-2583 (TTY: 711) hoặc liên hệ với nhà cung cấp dịch vụ của bạn để được hỗ trợ.

Yorùbá: ÀKÍYÈSÍ: Tí o bá nsọ Yorùbá, àwọn iṣẹ́ àtìlẹhin èdè lọ́fẹ̀ẹ́ wà lárọwọ́tó rẹ. Awọn iṣẹ́ àtìlẹhìn ìrànlọ́wọ́ tó yẹ láti pèsè ìwífúnni ni ọna iráàyèsi kíka wà lárọwọ́tó bakanna lọ́fẹ̀ẹ́. Pe 1-800-275-2583 (TTY: 711) tàbi ki ó bá olùpèsè rẹ sọ̀rọ̀.

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 less favorably because of race, color, national origin, age, disability, or sex.

This plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance 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, in person or by mail: 1901 Market Street, Philadelphia, PA 19103, by phone: 1-888-377-3933 (TTY: 711), by fax: 215-761-0245, or by email: **civilrightscoordinator@1901market.com**.

You can file a grievance in person or by mail, fax, or email. 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

This notice is available at the following website**:** **www.healthinsurancehosting.com/notices**.

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