Authorization for the Use or Disclosure of Protected Health Information

Use this form to authorize Health Partners Plans to use or disclose your health information to another person or organization.

INSTRUCTIONS FOR COMPLETING THIS AUTHORIZATION FORM

Part 1: Member information. This section should name the Health Partners Plans (HPP) member whose health information will be shared with and/or disclosed to the authorized person/organization. Print the member's name, birth date, address on file, telephone number, and Member ID number.

Part 2: Person or company who will receive this information. This section should name the authorized person/organization who will be contacting HPP to discuss the member's health information. A **separate form** must be completed for each person or organization. We suggest photocopying the blank form for multiple uses.

Part 3: Information that can be released. This section should indicate what health information Health Partners Plans may share with and/or disclose to the authorized person/organization.

Part 4: Purpose for the release or disclosure. This section tells us the reason you have asked for the release of your health information.

Part 5: Date your approval expires. The authorization requires a date be given or specific event for expiration of the authorization (e.g. 1/15/2025, January/2025, or a statement "when I am no longer a member"). If there is not a date or specific event provided, the form will expire in 6 months from when signed.

Part 6: Review and approval. The *member's* signature is required. If the member is incapable of signing, a personal or legal representative may sign on the member's behalf. Parents or guardians of minors will be confirmed using information from the state. A personal representative such as an executor or someone with a Power of Attorney may sign his or her name in the member's place. The legal documents proving the authority of the personal representative on behalf of the member **MUST** be attached or on file at HPP; otherwise the personal representative's signature will be invalid and this form will **NOT** be processed.

Disclosure: Notice regarding Re-Disclosure and Prohibited Use of Substance Use Disorder Information

HIV/AIDS and other sexually transmitted diseases, behavioral health, genetic markers, and Substance use diagnosis, treatment, or referral for treatment from a federally assisted Part 2 program are protected by Federal confidentiality rules which prohibit any further disclosure of this information unless you obtain written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. These rules prohibit anyone from using or disclosing these records, or any testimony describing information contained in these records, in any civil, criminal, administrative, or legislative proceeding by any Federal, State, or local authority against the patient, unless authorized by the patient's written consent or as authorized by a court in accordance with Part 2. Once lawfully received with appropriate consent, HIPAA-regulated entities may redisclose SUD information in accordance with HIPAA, except where Part 2 provides additional protection (for example, certain counseling session notes).

Complete ALL sections. If information on this form is not complete Health Partners Plans will return the form and will not approve this request until it is completed in full.

CONTACT INFORMATION

RETURN YOUR FORM(S) TO THE ADDRESS OR FAX NUMBER LISTED BELOW.

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

Health Partners Plans
Privacy Services
1101 Market Street, Suite 3000
Philadelphia, PA 19107
or
Fax: 267-515-6666

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

Authorization for the Use or Disclosure of Protected Health information

All fields are required.

1. Person whose information is to be disclosed (the "member").

Member Name:	Date of Birth:
Address:	City/ZIP:
Member ID #:	Telephone:

2. Who is authorized to receive the member's information (the recipient").

Recipient's or Organization Name:	Relationship to Member:
Address:	Telephone: Fax:

3. What health information may Health Partners Plans release? (Check all that apply.)

☐ **All** of my (member) protected health information.
☐ Benefit information only (copays, pharmacy, eligibility/coverage information)
☐ Coordination of care information only (such as care and control, social worker, or disease management information)
☐ Psychotherapy notes – ***If you check this box, you may not check any other boxes in this section***. *An authorization for the release of psychotherapy notes may not be combined with an authorization for disclosure of any other type of information*.
☐ Special instructions: _____

***NOTE:** Federal and state law requires that you provide specific permission to release the information below even if you checked a box above. Indicate your permission for Health Partners Plans to release any of the following information by initialing all that apply.

Genetic information _____ (Initials) **HIV/AIDS** _____ (Initials)
Alcohol/substance abuse _____(Initials) **Mental/behavioral health** _____ (Initials)

4. What is the purpose of the requested uses or disclosure of Information?

☐ To **discuss** my health information in person, writing, or by phone
☐ To **discuss and make changes to** my health information (such as Primary Care Physician changes)
☐ Other/special purpose: _____

5. Expiration and revocation

This Authorization **will expire** on __/__/_____ (month/day/year) **OR** upon the following event (e.g. "when I am no longer a member"). _____

6. Signature

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

A. My authorization is voluntary and not a condition of enrollment, eligibility, or claim payment.
B. If the authorized persons or organization listed above is not subject to federal or state health information privacy laws, they may further release my health information and it may no longer be protected by federal and state privacy laws.
C. I may revoke/cancel this Authorization at any time by sending written notice to Health Partners Plans or submitting the Revocation Form. However, I understand that any revocation/cancellation of this authorization will not affect any action taken by Health Partners Plans before it received my signed revocation.

MEMBER OR PERSONAL REPRESENTATIVE SIGNATURE

I have read and understand the above information:

Member or personal representative name (please print): _____

Signature: _____ Date:_____

If you are a personal representative, state your relationship to the member:_____

***Note that**, if not already provided, we will require verification of the authority of a personal representative such as a copy of a health care, general or durable power of attorney before this request will be considered complete.*

If this request is made by a parent/guardian, complete the following:
***Member/participant is a minor _____ years of age**.*
If you are making this request on behalf of a minor child, we may require additional information such as a court order or other documentations that shows custody or other legal document showing the authority of the legal representative to act on the member's behalf before this request is considered complete.