Designee Authorization To Use or Disclose Protected Health Information and To Access the Member Portal

GENERAL INFORMATION

By completing this form, you voluntarily authorize EmblemHealth to share your protected health information with the designee you have identified on this form. This includes, but is not limited to, authorizing your designee to access your member portal. This means that once your designee can sign in to your member portal, they will be able to view the information that you can see on the portal, including (but not limited to) your claim information, authorization requests, benefit information, eligibility, and demographic information. Through the member portal, your designee will also be able to view communications sent to you from EmblemHealth through your member portal, such as electronic utilization management notices about services you have requested or received as well as complaint and appeals notices. Your designee will be able to change your primary care provider (PCP) on the portal, download a temporary copy of your member ID card, and add coordination of benefit (COB) information to your account. In addition, your designee will be able to file a complaint or appeal on your behalf. Note: A designee of a Medicare member must use a separate Appointment of Representative form to file an appeal or complaint on the member's behalf. EmblemHealth may share this authorization form with its business associates to best assist you with your needs.

FORM INSTRUCTIONS

The instructions below explain the information that EmblemHealth needs from you. If you have questions or need help, call our Customer Service team at the number on your member ID card, or visit emblemhealth.com/contact for more information on how to contact us. We recommend that you read the entire form before you complete it.

Fill out the form completely.

1. **MEMBER INFORMATION:** Fill in your member ID number, name, address, phone number, and birth date.

2. **DESIGNEE INFORMATION**: This is the person(s) that you will allow EmblemHealth to share your information with. They will have the ability to access the information in your member portal and allow EmblemHealth to discuss your information with them if they call or write to us as described in the General Information paragraph above.

3. **PURPOSE OF THE AUTHORIZATION:** Tell us why you are asking us to share your information with your designee. Note that by completing this form, you will also grant your designee to access your member portal if they register.

4. **INFORMATION TO BE DISCLOSED:** Tell us the type of information you are authorizing us to share. This includes the ability of EmblemHealth to share your information with your designee. This includes, but is not limited to, the ability of your designee to view your member portal if they register. Once your designee can sign in to your member portal, they will be able to view the information that you can see on the portal, including (but not limited to) your claim information, authorization requests, benefit information, eligibility, and demographic information. Through the member portal, your designee will also be able to view communications sent to you from EmblemHealth through your member portal, such as electronic utilization management notices about services you have requested or received as well as complaint and appeals notices. Your designee will be able to change your primary care provider (PCP) on the portal, download a temporary copy of your member ID card, and add coordination of benefit (COB) information to

your account. In addition, your designee will be able to file a complaint or appeal on your behalf. Note: A designee of a Medicare member must use a separate Appointment of Representative form to file an appeal or complaint on the member's behalf.

NOTE: We will not share sensitive information like behavioral health and HIV/AIDS information unless you specifically tell us to. Write your initials where indicated to release any of this information. For your designee to view any of your sensitive information through the member portal, you must initial in the space provided next to each sensitive information category.

If you leave any of these lines blank, your designee will still have access to your member portal, but they will not be able to see information related to the specific sensitive condition. Your designee will **only** be able to obtain the sensitive information that you initial below by contacting EmblemHealth.

5. **TERM OF AUTHORIZATION:** Tell us how long we should continue to make your information available to your designee and when to revoke (cancel) your designee's access.

   - If you check the first box, you can fill in the day, month, and year that this authorization should end.
   - If you check the second box, you can provide a description of the event when this authorization should end.

   Important: If you do not give us any end date or event, your designee will have access to your information for 12 months from the date signed or, in the case of a minor, when the minor turns 18, whichever comes first.

6. **CONDITIONS OF AUTHORIZATION:** Read this section all the way through. It has important information about what can happen to your information after we share it.

7. **SIGNATURE REQUIRED:** We can't share your information with your designee unless you or your personal representative completes and signs the form. If a personal representative is submitting the request for you, they must sign this form. A personal representative is a person who, under law, has the authority to act on your or your dependent's behalf to make health care-related decisions.

   The request must include written proof of your personal representative's authority to complete and sign this form for you, such as proof of legal guardianship or durable power of attorney. We need this proof to make sure that this person has the right to act on your or your dependent's behalf.

   Note that some forms, like a durable power of attorney form, may only give a personal representative a limited right. The right(s) given to the representative must include the ability to request and receive protected health information. This may be done by giving the individual the right to make health care decisions.

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All required sections (marked with an *) of this form must be completed for it to be valid. See the instructions for more information on how to complete this form. Once you have filled out the form completely, send it to EmblemHealth at the address shown at the end of the form.

1. MEMBER INFORMATION*

Member ID Number:____
Member Name: ____
Mailing Address: ____
Phone Number (optional):____
Date of Birth: ____

2. DESIGNEE INFORMATION*

This is the person(s) or organization(s) I am authorizing EmblemHealth to share my information with, and who I authorize EmblemHealth to grant access to view the contents contained within my member portal and to make certain updates on my behalf:

Name: ____
Address: ____
Phone Number (optional):____
Email Address: ____
Relationship: ____

3. PURPOSE OF THE AUTHORIZATION*

At my request._____ OR ____

For the following purpose(s): (please explain) ____
____
____
____
____

4. INFORMATION TO BE DISCLOSED*

By signing this form, I voluntarily authorize EmblemHealth to share my protected health information with the designee I have identified on this form. I also authorize my designee to access my member portal if they register. My designee will be able to view the information that I am able to see on the portal including, but not limited to, my claim information, authorization requests, benefit information, eligibility and demographic information, and communications sent from EmblemHealth through the member portal, such as electronic utilization management notices about services I have requested or received as well as complaint and appeals notices. My designee will also be able to change my PCP on the portal, download a temporary copy of my member ID card, and add COB information to my account. In addition, my designee will be able to file a complaint or appeal on my behalf.

Note: A designee of a Medicare member must use a separate Appointment of Representative form to file an appeal or complaint on the member's behalf.

Sensitive Information*
Initial below to allow the sensitive information categories to be shared with my designee.

Important: For your designee to view any of your sensitive information through the member portal, you must initial in the space provided next to each sensitive information category. If you leave any of these lines blank, your designee will still be able to view your member portal, but they will not be able to see information related to the specific condition. Your designee will **only** be able to obtain the sensitive information that you initial below by contacting EmblemHealth.

____ All substance use disorders (alcohol/drug)
____ HIV/AIDS
____ All of the following conditions:
Genetic markers
Mental health (except psychotherapy notes)
Family planning
Sexually transmitted disease

5. TERM OF AUTHORIZATION OF THE DESIGNEE*
☐ Designee access will end on: (month/day/year) ___/___/___ ***OR***

☐ Designee access will end upon the following event: __________________________

Important: If you state an event rather than a specific date, it may be necessary for you to submit a revocation when the event occurs. If you do not specify an end date or event, this authorization will remain in effect until any of the following events occurs: 1. 12 months from the date this Authorization Form was signed; 2. You "revoke" or cancel it in writing; or, 3. In the case of a minor, when they turn 18.

Revoking or canceling the designee access
I understand I that have the right to revoke (cancel) this authorization at any time. The revocation (cancelation) must be in writing, signed and dated, and sent to the address at the end of this form. Any revocation (cancelation) will be effective as soon as EmblemHealth receives my written notice. I understand that EmblemHealth may have released information based on my earlier authorization before they received the revocation (cancelation).

6. CONDITIONS OF AUTHORIZATION
I understand that:

- The information contained in my member portal or otherwise shared with my designee may be further disclosed by the designee and no longer protected by state and federal privacy laws.
- I may refuse to sign this authorization. If that happens, EmblemHealth cannot require me to sign it to enroll or stay enrolled in my plan. I will still be eligible for health benefits and my treatment will not be affected by whether or not I sign this Authorization Form. EmblemHealth may not require me to sign it to pay for or receive specified health benefits.
- I understand that this form does not allow EmblemHealth to disclose psychotherapy notes. Psychotherapy notes are those notes that are taken by a mental health professional during my appointment. If those notes are needed, I understand that I must fill out a separate form (Authorization to

Use or Disclose Psychotherapy Notes), which can be requested by calling Customer Service at the number on my member ID card.

- If I authorize EmblemHealth to release HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited by law from sharing that information without my authorization, unless permitted to do so under federal or state law.
- If I am discriminated against because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at **888-392-3644** (TTY: **718-741-8300**). This agency is responsible for protecting my rights. I understand that the phone numbers I provided on this form may be used by EmblemHealth or any of its contracted parties to contact me about my account, my health benefit plan or related programs, or services provided to me.
- I voluntarily authorize EmblemHealth to share my protected health information with the designee I have identified on this form. I understand this authorization also allows my designee access to my member portal if they register. They will be able to see the information that I am able to see on the portal, including, but not limited to, my claim information, authorization requests, benefit information, eligibility and demographic information, and communications sent from EmblemHealth through the member portal, such as electronic utilization management notices about services I have requested or received as well as complaint and appeals notices.
- I understand that if I want to make any changes to the information that is shared with my designee, I will need to submit a new designee authorization form.

7. SIGNATURE REQUIRED*

___Check here if you are signing as an authorized personal representative and provide your information below. Please attach appropriate documentation (e.g., legal guardian, power of attorney, court order). If you do not provide the required documentation, the designee request will be denied or delayed, and you may have to resubmit it. For more information, please see the Instructions.

Printed Name: ____

Relationship to the Member:____

The member or an authorized personal representative **must sign** this form. In most instances, a parent must sign for a dependent child under 18 years old. I have read and understood the terms of this authorization. I have also had a chance to ask questions about how my health information will be used and shared. By signing this authorization, I confirm that the information on this form is complete and accurate, and follows my wishes. I authorize the use and disclosure of my health information in the manner described in this form.

Member Signature:____ Date:____________

Personal Representative Signature:_________________________________ Date:____________

____ Parent ____ Legal Guardian* ____ Power of Attorney* ____ Other*

*You must include documentation that proves you have legal authority to act for the member.

PLEASE KEEP A COPY OF THIS COMPLETED REQUEST FORM FOR YOUR RECORDS.

Once you have completed this form, please attach the necessary documentation and mail to:

EmblemHealth
Customer Service Department
P.O. Box 1701
New York, NY 10023-1701

EmblemHealth Plan, Inc., EmblemHealth Insurance Company, EmblemHealth Services Company, LLC, and Health Insurance Plan of Greater New York (HIP) are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.