AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

EmblemHealth, Inc. is the parent organization of the following companies that provide health benefit plans: Group Health Incorporated (GHI), HIP Health Plan of New York (HIP) and HIP Insurance Company of New York, Inc. (HIPIC). All of these entities receive administrative and other services from EmblemHealth Services Company, LLC, which is also an EmblemHealth, Inc. company.

By completing this form, you are authorizing your plan to use or disclose your protected health information, as defined by law, for the purpose stated below. This form may not be used to authorize release of psychotherapy notes. If you would like to authorize release of psychotherapy notes, you must complete the *Authorization to Use or Disclose Psychotherapy Notes* form.

FORM INSTRUCTIONS

Important: The instructions below explain each numbered section of the authorization form. Please refer to them as you complete the form. If you have additional questions, please contact the Customer Service department at the number on the back of your ID card.

SECTIONS

1 Member Information: Fill in member data carefully and completely.

2 Recipient of Information: Tell us to whom you are asking us to release the information.

3 Purpose of the Authorization: Check the box that applies and add any other information that we may need to know in order to disclose your information.

4 Information to Be Disclosed: Tell us which information you are authorizing your plan to disclose by checking the appropriate box. If you want only specific information disclosed, tell us what type of information you would like us to disclose. We will not disclose certain types of information (such as behavioral health and HIV/AIDS information) unless specific authorizations are given or otherwise permitted or requested by law. Initial in the blanks to release any of this information.

5 Term of Authorization: How long should your plan continue to release this information? Please check the first box and fill in the day, month and year that this authorization should remain in effect. Or, check the second box and describe when this authorization should expire (end). Please note that if you do not provide an expiration (end) date, your authorization will stay in effect for 24 months from the date signed.

6 Conditions of Authorization: Please read this section all the way through.

7 Signature Required: Sign and date on the line provided to complete this authorization. If a personal representative (someone with legal authority to act on the member's behalf) is signing this authorization, check the appropriate box, explain your relationship to the member and provide documentation of legal authority to act on the member's behalf.

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Please fill in member data carefully and completely, otherwise the form will not be considered valid. Use the instruction sheet to guide you. After completing, mail it to your plan at one of the following:

GHI or EmblemHealth PPO program members:
Customer Service Dept., PO Box 1701, New York, NY 10023-1701.

HIP or EmblemHealth CompreHealth program members:
Customer Service Dept., Member Interview Unit, 55 Water Street, New York, NY 10041-8190.

1 Member Information:

Member #: ______________________________

Member Name: ______________________________

Home Address: ______________________________

Home Telephone Number: ______________ Date of Birth: ______________

2 Recipient of Information:

Name: ______________________________

Address: ______________________________

Telephone: ______________ Relationship: ______________

3 Purpose of the Authorization:

☐ At my request.

OR

☐ For the following purposes: ______________________________

4 Information to Be Disclosed:

I authorize my plan to disclose my protected health information as follows:

☐ All clinical, claims, billing, benefit or coverage information.

OR

☐ Specific information only. Please list: ______________________________

____

Initial below to allow information or records related to any of the following to be shared with the authorized person. Release of the following information requires specific authorization.

________ Alcohol abuse/substance abuse
________ Behavioral health (excluding psychotherapy notes)
________ Genetic markers
________ HIV/AIDS
________ Sexually transmitted disease

5 Term of Authorization:

☐ Authorization should expire (end) on ____/____/_____
(month) (day) (year)

OR

☐ Upon the following event: ____

NOTE: I understand that if I fail to specify an expiration (end) date or event, the authorization will remain in effect until I revoke (cancel) it in writing or 24 months from the date that I signed this form, whichever is earlier.

6 Conditions of Authorization:

I understand that:

- The information disclosed under this authorization may be further disclosed by the recipient and no longer protected by state and federal privacy laws.
- I have the right to revoke (cancel) this authorization at any time, and that the revocation (cancellation) must be in writing and sent to the address noted on this form.
- Any revocation (cancellation) will become effective as soon as my plan receives my written notice. I understand that the revocation will not affect any action taken by my plan in reliance on the authorization prior to receiving my written notice of revocation.
- I may refuse to sign this authorization. My plan will not condition my enrollment or eligibility for health benefits on my provision of the authorization. My plan may not condition payment of a claim for specified health benefits on my provision of this authorization.
- If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at **1-888-392-3644**. This agency is responsible for protecting my rights.

7 Signature Required:

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 disclosed. By signing this authorization, I am affirming that to the best of my knowledge all information provided on this form is complete, accurate and consistent with my directions. I hereby provide my agreement to the terms authorizing the use and disclosure of my health information in the manner described in this form.

Signature of Member ______________________________ Date ______________

NOTE: The signature of the member or his or her personal representative (someone who has legal authority to act on the member's behalf) is necessary. A parent must sign for a minor dependent child.

Signature of Personal Representative ______________________ Date ______________

☐ Parent ☐ Legal Guardian* ☐ Power of Attorney* ☐ Other* ____________

*Provide documentation supporting your legal authority to act on the member's behalf.