Authorization to Release Information

The enclosed Authorization form is required in order to allow your health plan to release protected health information to another person or organization. Please review and complete the form. A number of important points are highlighted here, for more detailed instructions please refer to the instructions on the back of the Authorization Form. If you have any questions please contact the member services department number listed on the back of your member identification card.

Each section of the form must be completed; missing information will result in delays in processing the authorization.

- ❑ Include your Social Security/Member Identification Number
- ❑ List in the "Recipient" section the name of the person or organization to whom you are authorizing your health plan to release information. Be sure to include the recipient's contact information such as telephone number, fax number or address.
- ❑ Review the "Description of the Information to be Released" section before completing.
  - ✓ You should only check **one** of the three boxes listed.
  - ✓ If you select the "Psychotherapy Notes" box, you cannot check any other box
  - ✓ If someone routinely assists you with your health care, for example, husband, wife, son or daughter, you may want to give that person access to all your information. To do this check the second box in this section and initial any/all applicable areas in the *Notes section.
  - ✓ Check the "Specific Information" box if an individual is assisting you in resolving a particular issue such as an appeal, and initial any/all applicable areas in the *Notes section.
  - ✓ A "Purpose of Release" must also be noted.
- ❑ An "Expiration" must be listed. You can allow the authorization to remain in effect until you revoke it in writing. You may also indicate that the authorization will expire on a specific date or at the conclusion of an event, such as an appeal.
- ❑ You or your personal representative must sign the authorization. If a personal representative signs the authorization a copy of the legal documents must be submitted with the authorization.
- ❑ Return the completed authorization form to the following address:

Member Correspondence
P O Box 41890
Philadelphia, PA 19101-1890
Fax Number: 215-241-2042

Important Information about Personal Representatives

- The new federal Privacy Rule, also known as the HIPAA Privacy Rule, requires your health plan to follow certain procedures before it may provide access to your Protected Health Information (PHI) to someone other than you. PHI is information about you that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, and the provision of health care to you or the payments for that care.

- Your health plan will release PHI to an individual's Personal Representative upon written verification of such status. Acceptance of a Personal Representative will depend on the extent of their legal authority to make health-related decisions on behalf of the individual, such as whether they have Power of Attorney or guardianship.

- A parent of a minor is generally considered a minor's Personal Representative unless otherwise required by applicable law. If the parent is not insured by your health plan, he/she will need to submit documentation to verify his/her parental status.

- Your health plan will recognize as a Personal Representative an executor, administrator, or a person recognized by law as having authority to act on behalf of a deceased individual or the individual's estate.

- Your health plan will not however, treat someone as your Personal Representative if we reasonably believe (1) you may be subject to domestic violence, abuse or neglect by the Personal Representative; (2) treating the person as your Personal Representative could endanger you; or (3) in the exercise of professional judgement (for example, in a licensed professional's judgement), your health plan decides that it is not in your best interest to treat the person as your Personal Representative.

- A Personal Representative designation will remain in effect until the individual, a court order, or an applicable law revokes it.

- To assist your health plan in responding to this request, please complete this form by printing or typing into the spaces provided. Attach additional pages if necessary to clarify your request.

- Mail or fax the completed form and supporting documentation to:

Member Correspondence
P.O. Box 41890
Philadelphia, PA 19101-1890
Fax Number: 215-241-2042

- If you have any questions about his form, please call the Member Services Department at the number on the back of your member identification card.

Personal Representative Request Form

[Please print]

This form identifies the person who has legal authority to act on a member's behalf in making decisions related to the member's health care. This provision applies to persons with legal guardianship, power of attorney, or other documented legal authority to act on behalf of a member. **Questions regarding this form should be directed to the Member Services Department at the number located on the back of the member's identification (ID) card.**

Member Information: Include any letters in front of the identification number on the member ID card

Name: (First, Middle, Last, Title)	**Date of Birth:** (Month/Day/Year)
Address: (including zip code)	**Gender:** ☐Male ☐Female
Home Telephone Number: (including area code)	**Member ID Number:**
Group Name/Number: (if available)	**Social Security Number:** (optional)

Health Plan (The Health Plan is your insurance carrier or HMO. Please enter the Health Plan name as it appears on the member's ID card.)

Personal Representative Information:

Name: (First)	(Middle Initial)	(Last)	Title (Sr., Jr., III)	**Personal Rep. Mother's Maiden Name:** (Required for verification purposes)
Address: (including Zip Code)				**Telephone Number:** (including Area Code)

A copy of a Power of Attorney or other court-initiated document must be attached to this form in order for it to be processed. Attach supporting documentation and describe (for example: Power of Attorney for health care decisions, Custodial Order, Executor of Estate).

Type of Documentation:

Signature/Date (The member's legal personal representative must sign and date this form for it to be processed.)

Personal Rep. Signature: ______________________________

Date: ____________________