Authorization to Release Information

[Please Print]

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.

Section A. Member Information: (individual whose information will be released)

Name: (First, Middle, Last, Title)	**Member ID Number:**	**Group Number:**
Address: (including zip code)	**Telephone Number:** (including area code)	
Date of Birth: (Month/Day/Year)		

Section B. Health Plan: (organization that will release your information)

I authorize **AmeriHealth Administrators** to release my protected health information as described below.

Section C. Recipient: (person or organization that will receive your information)

Person's Name or Organization:	**Address:** (including zip code)
Telephone Number: (including area code)	**Fax Number:** (if available)

Section D. Description of the Information to be Released: (what type of information will be released)

Check ONLY ONE box:

☐ **Psychotherapy notes** – Federal law requires a separate authorization to use or release psychotherapy notes.
If you check this box, you may not check another box below.

☐ **All information related to the provision of and payment for my health care benefits or services.***

☐ **Specific information as described on the line below:***

_____

Examples: The claim related to my service on (date); Appeal information related to my claim on (date)

***NOTE**: State law requires that you give specific permission to release the information below even if you checked a box above. Indicate your permission for the Health Plan to release any of the following information by initialing all that apply.

Genetic Information _____ (Initials) **HIV/AIDS** _____ (Initials)
Substance/Alcohol Abuse _____ (Initials) **Mental/Behavioral Health** _____ (Initials)

Purpose of Release: _____

Examples: At my request; To resolve my appeal; To assist with my health insurance services

Section E. Expiration: (when this authorization will end)**

This authorization will expire (Check ONLY ONE box):

☐ **When I revoke this authorization*** ☐ **Upon the following date, event or condition*:**_____

Note: This authorization will terminate on the earliest of the events listed above or 180 days after termination of coverage.

*** The party identified in Section B must be notified in writing of the event/condition to cancel or revoke this authorization. ** Please note: State law requires that this Authorization to Release Information will automatically expire in 12 months for Minnesota residents and in 24 months for Montana residents unless you specify a shorter timeframe.**

Section F. Approval: (You OR your Personal Representative must sign and date this form in order for it to be complete.)

I understand that this authorization to release 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.

_____
(Print Name)

_____
(Signature of Member)

_____
(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)

Instructions - Authorization to Release Information

This form is used for you or your Personal Representative to authorize the Health Plan to release your protected health information to another person or organization at your request.

"Protected health information," means individually identifiable health information. It is information about you, including your name, address and medical information and may relate to your past, present or future physical or mental health or condition. The Health Plan maintains information that may include eligibility, benefits, claims or payment information.

Section A. Member Information: (individual whose information will be released)

Print your complete name, member ID number, address, date-of-birth, telephone number, group number and social security number.

Important: Provide the Member ID Number located on the front of your Health Plan identification card. Be sure to include any letters in front of the identification number.

Section B. Health Plan: (organization that will release your information)

The Health Plan is your insurance carrier or HMO that maintains information about you. Print the name of your Health Plan on the line provided.

Section C. Recipient: (person or organization that will receive your information)

The recipient is a person or organization that you choose to receive your protected health information from the Health Plan. You must provide all of the contact information in order for the information to be released.

- Identify the person, family member or organization to receive your information.
- Provide the contact information about the person, family member or organization to receive your information.

Section D. Description of the Information to be Released: (what type of information will be released)

You must indicate or describe the information to be released. **Check ONLY ONE box that best describes your request**. There are three choices. The first choice is **Psychotherapy Notes**. The second choice is **All Information**. The third choice is **Specific Information** that you must describe on the line provided. **CHECK ONLY ONE BOX.**

If this authorization is to release psychotherapy notes, the Health Plan cannot release any other information unless you complete another Authorization to Release Information form.

- **Psychotherapy Notes** are notes recorded by a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session. These notes are separated from the rest of the individual's medical record. **Psychotherapy notes cannot be combined with an authorization to release any other type of information.**
- **All Information.** If you check this box, the Health Plan may release all information related to the provision of a payment for your health care benefits or services. If someone is directly involved in coordinating your health care or benefits, you may want them to have access to all of your information.
- **Specific Information.** By checking this box, you indicate that you want only specific information to be released. Describe the specific information on the line provided.

Purpose of Release. Provide a brief description of the reason you want this information released. The statement, "At my request" is sufficient.

IMPORTANT: State law requires that you give specific permission to release certain health information. Your initials are required on each line in order for the Health Plan to release information for HIV/AIDS, Substance/Alcohol Abuse, Genetic information or Mental/Behavioral Health information.

Section E. Expiration: (when this authorization will end)

Print either an expiration date OR event, but not both. If an expiration event is used, the event must relate to the purpose of the release of information being authorized.

****Please note: State law requires that this Authorization to Release Information will automatically expire in 12 months for Minnesota residents and in 24 months for Montana residents unless you specify a shorter timeframe. If you are a resident of Minnesota or Montana and the expiration you indicate is greater than these time periods, the authorization will automatically expire as required by state law.**

Section F. Approval: (You OR your Personal Representative must sign and date this form in order for it to be complete.)

Member Signature.	Personal Representative Information.
If you are the individual whose information will be released, you must sign and date in this section.	If you are the Personal Representative, the member's signature is not required. However, you must provide the requested information, signature and date. A copy of the legal authority, such as a Power of Attorney or other legal document, must be on file at the Health Plan or be submitted with this form.

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 at the 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 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, list the specific information on the line below the box and initial any/all applicable areas in the "Notes" section.
  - ✓ A "Purpose of Release" should 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. Please note that State law requires that an authorization expire in no more than 12 months for **Minnesota** residents and in no more than 24 months for **Montana** residents.
- ☐ You or your Personal Representative must sign the authorization. Only one signature is required. If a Personal Representative signs the authorization, a copy of the legal documents showing they have authority to act on the member's behalf must be on file at the Health Plan or submitted with the authorization.
- ☐ Return the completed authorization form to the following address:

AmeriHealth Administrators
720 Blair Mill Road
Horsham, PA 19044
Attn.: Privacy Official

Phone Number: 215-830-2579
Fax Number: 215-238-7993