An Important Note Regarding Protected Health Information

The personal health information provided to you has been disclosed from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 C.F.R. Part 2. A general authorization form for the release of medical or other information is <u>not</u> sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol abuse patient. 42 C.F.R. § 2.32.

Independent Health
Dedicated to Making a Difference

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

This form authorizes Independent Health to use or disclose your protected health information (PHI). This authorization is voluntary. You may refuse to sign this authorization but then Independent Health will not be able to release your information. Signing or not signing this form will not affect any payment, enrollment or eligibility for benefit decisions made by Independent Health. You may revoke this authorization at any time by writing to Independent Health's Member Services Department at 511 Farber Lakes Drive, Buffalo, NY 14221. A copy of this signed authorization will be available to you, but you should retain a copy for your records.*

SECTION 1: TELL US WHO YOU ARE (Please print and complete all information)

Name: _____ Date of birth: _____

Address: _____ Phone Number: (_____)_____

City, State, Zip_____

Independent Health Member ID number: _____

SECTION 2: WHAT IS THE PURPOSE OF THIS AUTHORIZATION? (Please check all that apply)

□ To authorize the identified persons and/or organizations to discuss orally with Independent Health the PHI indicated and as permitted by Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

□ To authorize the identified persons and/or organizations to inspect and/or obtain copies of the PHI indicated as permitted by the HIPAA Privacy Rule.

SECTION 3: WHO IS AUTHORIZED TO RECEIVE YOUR PROTECTED HEALTH INFORMATION (PHI) FROM INDEPENDENT HEALTH? (Please indicate the person and/or organization's name and address)

Name/Organization	Address
1.	
2.	
3.	

SECTION 4: WHAT PHI DO YOU AUTHORIZE US TO DISCLOSE? (Please check all that apply)

Claim Information (status, type of service, diagnosis, provider dates of service):

□ Physician □ Hospital □ Pharmacy □ Dental □ Mental Health □ Substance Abuse

□ Benefit Information (*e.g.,* Available benefits, used benefits, contract limitations)

□ Member Information (*e.g.,* Coverage, enrollment, eligibility, address, date of birth)

□ Other (e.g., Case management notes, appeals) _____

Selecting any of the boxes above will allow the authorized person to obtain information from the effective date of your current plan with Independent Health, unless indicated below.

□ Respond to inquiries related to the specific date(s) of service: _____

SECTION 5: WHEN DO YOU WANT THIS AUTHORIZATION TO EXPIRE? (Please check one)
□ Two years from the date I signed this authorization.
□ Until I send Independent Health a letter canceling my authorization.

SECTION 6: SIGNATURE

I understand that if the entity authorized to receive my PHI is not a health plan, health care provider or other covered entity as described by the HIPAA Privacy Rule, the released information may no longer be protected by federal privacy laws, rules and regulations. I understand that the information disclosed may include mental health information and/or alcohol and substance abuse information. I understand that I am not required to sign this form, but if I do not sign this form, it will not be considered valid and will be returned. I understand that I may revoke this authorization at any time by notifying Independent Health in writing. If I do revoke this authorization, I understand that my revocation will have no effect on any actions Independent Health took according to this authorization before Independent Health received my revocation.

I agree that this information is true and correct. I sign this authorization under penalties of perjury and attest that Independent Health may rely on my signature and the contents of this authorization.

_____ Date: _____
Signature of Member
(If you are acting on behalf of the member listed in Section 1, complete Section 7)

SECTION 7: PERSONAL REPRESENTATIVE

If you are acting on behalf of the member listed in Section 1, you are called the member's Personal Representative and you must complete this section.

Print Name of Personal Representative: _____

Signature of Personal Representative: _____

Please include a copy of one of the following documents as proof of legal representation:
□ Valid health care proxy
□ Certificate of Guardianship issued by a New York State Supreme Court or Surrogate Court
□ Letter if incapacity from the member's physician

If the member is deceased, please submit a copy of one of the following:
□ Administrator's Certificate
□ Executor's Certificate
□ Surviving Spouse's Certificate issued by a New York State Surrogate Court

If you need help in filling out this form, please call the Member Services Department, Monday through Friday from 8 a.m. to 8 p.m., at (716) 631-8701 or 1-800-501-3439. Our Telecommunications Device for the Deaf number is (716) 631-3108.

**Independent Health includes Independent Health Association, Inc., Independent Health Benefits Corporation and Independent Health Corporation*

Verbal translation, alternate formats of written materials, and/or assistance for those with special needs, may be available upon request.

Traducción verbal, formatos alternativos de materiales escritos y/o asistencia para quienes tienen necesidades especiales, disponibles a solicitud.