Authorization to Disclose Protected Health Information (PHI)

Under Federal and State privacy laws, Independent Health is authorized to use or disclose your Protected Health Information (PHI) with your health care providers for payment, treatment and health care operations. For purposes other than treatment, payment or health care operations, your written authorization is required before sharing your PHI. This includes sharing your information with your spouse, relatives, employer, etc. This form allows you to authorize Independent Health to use or disclose your PHI to those individuals you specify in this form.

Please read before completing this form

- Incomplete authorizations will be considered invalid and will not be accepted. Incomplete authorizations will be returned.
- Completion of this authorization form is voluntary. You may refuse to sign this form, but then Independent Health will not be able to release your information.
- A copy of this authorization will be available to you, but you should retain a copy for your records.
- Signing or not signing this form will not affect any payment, enrollment or eligibility for benefit decisions made by Independent Health.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described in this authorization may be disclosed to other individuals or institutions and no longer protected by these regulations.
- Finally, you may revoke this authorization in writing at any time by sending Independent Health a letter or completing Independent Health's Authorization Revocation Form. To obtain a copy of this form, visit the "Useful Links" section of our website at www.independenthealth.com and click on the "Frequently Used Forms" link. Or, call Independent Health's Servicing Department at (716) 631-8701 or 1-800-501-3439, Monday through Friday from 8 a.m. to 8 p.m. Telecommunications Device for the Deaf (TDD): (716) 631-3108 or 1-800-432-1110. Your revocation notice will not apply to actions taken by the requesting person/entity prior to the date we receive your written request to revoke authorization.

Mail your completed and signed authorization to:

Independent Health
P.O. Box 1642
Buffalo, NY 14231

If you need assistance completing this form, please contact Independent Health's Servicing Department at the number listed on the back of your Identification Card.

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Section A: Member Information Complete all information requested in this section for the member whose information will be released.		
Name: (Last, First, Middle Initial, Title [Sr., Jr., III.])	**Date of Birth:** / /	**Telephone Number:** ( )
Address:	**Group #:** (as shown on the member's ID card)	
City, State, Zip:	**Member ID #:** (as shown on the member's ID card) ☐☐☐☐☐☐☐☐☐ - ☐☐	

Section B: Authorized Individuals Please list the individuals and/or organizations that you are authorizing to view or receive your PHI. Include each individual's address and telephone number incase they need to be contacted in an emergency.		
1.	**Name/Organization:**	**Relationship:**
	Address:	**Telephone Number:** ( )
2.	**Name/Organization:**	**Relationship:**
	Address:	**Telephone Number:** ( )

Section C: Description of Information that can be Released (Please check/initial all that apply)
If more space is needed to describe the PHI, attach an additional page. Please note: a special New York State authorization form is required for disclosing confidential HIV-related Information. To obtain a copy of this form please visit our website at www.independenthealth.com then under useful links, click on Frequently Used Forms or call our Servicing Department at the number listed on the back of your ID card.

☐ Pre-Cert / Referral Information	☐ Enrollment / Benefits	☐ Disease Management
☐ Case Management Information	☐ Payment Information	☐ Pharmacy Information
☐ Claims Information (Medical and Dental)	☐ Health Management	☐ Demographic Information

☐ Other: *(Please specify)*_____

☐ **All of the above** (Does not include below)

I understand that **my specific authorization** is needed to release my information pertaining to the items listed below. By initialing, I authorize release of the following information pertinent to my case:

Pregnancy/Reproductive	**Psychotherapy/Mental Health**	**Alcohol/Substance Abuse**
_____ (Initials)	_____ (Initials)	_____ (Initials)

Section D: Time Period
Unless noted below, the authorized individuals in Section B can obtain your PHI from the coverage date of your plan with Independent Health.

☐ Only respond to inquires from (insert date) _____ to (insert date) _____

Section E: Scope of Authorization (Please check all that apply, This section must be completed)

☐ The individual(s) in Section B may discuss orally my PHI with Independent Health.

☐ The individual(s) in Section B may inspect and/or obtain copies of my PHI from Independent Health.

☐ The individual(s) in Section B may change my Primary Care Physician (PCP) and my address maintained by Independent Health.

Section F: Expiration (Please check one)

Unless noted below, this authorization is valid until Independent Health receives a letter canceling this authorization.

This authorization will expire:

☐ 1 year from the date of my signature

☐ 3 years from the date of my signature

☐ 5 years from the date of my signature

☐ On the following date (*insert date*): _____

☐ On the following event: *(please specify)* _____

Section G: Personal Representative Information

Complete this section if you are a personal representative that is acting on behalf of a member. You must include a copy of one of the following documents as proof of your legal representation and authority:

□ Valid health care proxy

□ Certificate of Guardianship issued by a New York State Supreme or Surrogate Court

If the member is deceased, please submit a copy of one of the following:

□ Administrator's or Executor's Certificate

□ Surviving Spouse's Certificate issued by a New York State Surrogate Court

Name: (Last, First, Middle Initial, Title [Sr., Jr., III.])	**Relationship:**
Address:	**Telephone Number:** ( )

Section H: Signature/Date

Please read the following carefully before you sign.

By signing this form, I understand the following: (1) if the entity authorized to receive my PHI is not a health plan, health care provider or other covered entity as described by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, the released information may no longer be protected by federal privacy laws, rules and regulations; (2) the information disclosed will only include mental health, alcohol and substance abuse, HIV/Aids, sexually transmitted disease, abortion and/or genetic testing information if I specifically direct Independent Health to release that information; (3) I am not required to sign this form, but if I do not sign this form, it will not be considered valid, it will be returned to me and no information will be released by Independent Health; (4) I may revoke this authorization at any time by notifying Independent Health in writing; (5) if I do revoke this authorization, my revocation will have no effect on any actions Independent Health took according to this authorization before Independent Health received my revocation; and (6) it is my choice whether I sign this form and signing or not signing this authorization will not affect any payment, enrollment, or eligibility for benefit decisions made by Independent Health.

I sign this authorization under penalty of perjury and attest that the information contained in this authorization is true and correct and may be relied upon by Independent Health.

_____ **Date:** _____

Signature of Member or Personal Representative