Premier Health Plan

# MEMBER AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

You have indicated that Premier Health Plan may use or disclose your protected health information (PHI) that we have received, collected, or maintained in our files for certain purposes that, according to federal law, require your written permission.

> Please be advised Premier Health Plan does **not** receive, collect, or maintain any medical records or hospital charts. You must contact your physicians or hospital for authorizations for these types of records.
>
> We also do not handle dental insurance. Please contact your dental provider or insurer for dental information.

Your privacy is important to us, as are your rights. In order to ensure that your records are properly protected, we need to have written confirmation of the details of your authorization for use or disclosure of your PHI.

Please take a moment to complete this authorization form. Once you return this completed, signed, and dated form to us, we can verify your information, adjust our records accordingly, and use or disclose the PHI that you have indicated.

**Please read this accounting of disclosures request form carefully and fill it out completely. Please print or type in the information requested; if printing, please use a pen.**

## Member Information

| Member Name | | | |
|---|---|---|---|
| Member Address | | | |
| Member ID Number | | Social Security No. | |
| Date of Birth | ____ / ____ / ____ | Phone Number | |

*Please provide a telephone number. We may need to contact you about the information you have provided on this form.*

I, the above-named member, authorize Premier Health Plan to use or disclose my PHI, as follows:

## Required Information

The type and amount of information that I am authorizing to be used or disclosed is:
(Please check the appropriate items and/or write in any other specific records, where indicated)

| | Medical/surgical claims information | | Pharmacy claims |
|---|---|---|---|
| | Vision benefit claims | | Behavioral health |
| | Chemical dependency claims | | Member Services records |
| | Member complaint/grievance files | | Special needs department records |
| | Other records (please specify) | | |

Please specify the health care provider or facility and dates of service or time frame of requested records (if applicable):

Premier Health Plan



**Premier Health Plan Department Authorized to Make the Use or Disclosure**

| The Premier Health Plan staff person or department authorized to make the requested use or disclosure is<br>*If there is no specific person or department, please write in "Member Services Department"* | |
|---|---|

**Person or Organization to Whom Disclosure Is to Be Made**
I authorize disclosure of the above-indicated records to the following:

| Name | | | |
|---|---|---|---|
| Company/Organization | | | |
| Address | | | |
| Phone Number | | Fax Number | |

**Purpose of Use or Disclosure**
The purpose of the requested use or disclosure is as follows:

*If you prefer not to be specific, please write in "at the request of the member."*

**Expiration of Authorization**
Expiration date (or event) for the use or disclosure authorized in this form is: ____ / ____ / ____
(If no expiration date is indicated, Premier Health Plan will use the end of the current contract year for your health benefits. If this use or disclosure is for research purposes, please write in "none" or "at end of research.")

**Need to Renew Authorization**
If I do not revoke this authorization, I understand that it will expire on the expiration date indicated in #5 above. If I wish to extend the authorization, I must renew the authorization by completing a new authorization form.

**Right to Revocation**
I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and submit my written revocation to Premier Health Plan Member Services Department. I understand that this revocation will not apply to information that has already been released in response to my initial authorization.

**Lack of Conditions**
I understand that I do not need to sign this authorization form in order to receive health care treatment, payment, enrollment in my health plan, or eligibility for health care benefits by Premier Health Plan.

**Risk of Disclosure to Persons Not Covered Under HIPAA Privacy Rules**
I realize that the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations are meant to ensure the privacy of my health information. I understand that once my PHI is disclosed according to my instructions on this form, if the information is disclosed to persons not subject to the federal HIPAA Privacy regulations that the information may be subject to re-disclosure by the recipient. The PHI disclosed may then no longer be protected by federal privacy regulations. I understand that this is particularly important in the case of any disclosure of my PHI to my employer.

**Right to Retain Copy of the Authorization**
I understand that I have the right to retain or receive a copy of this authorization.

| | |
|---|---|
| | Please check if you are not making a copy of this authorization form for your own records and want to receive a copy from Premier Health Plan. |

## Required Signature

| Member Signature | | Date | ____ / ____ / ____ |
|---|---|---|---|

**Please note:**
In the event that the member is a minor or otherwise legally incompetent, please provide the name, address, and relationship to the member of the person who is signing the access request form.

| Name | | Relationship | |
|---|---|---|---|
| Address | | | |

If this confidential communication request form is being submitted by the personal representative of the member, please provide signature.

| Personal Representative Signature | | Date | ____ / ____ / ____ |
|---|---|---|---|

## How to Submit this Form

Mail
Premier Health Plan
PO Box 3470
Pittsburgh, Pennsylvania 15230-3470

If you have any questions about this Member Authorization form, please call the Member Services Department at the number on the back of your ID card.