

Authorization to Disclose Protected Health Information (PHI)

Under Federal and State privacy laws, Independent Health Association, Inc. and its affiliates ("Independent Health") is authorized to use or disclose your health information for payment, treatment and health care operations and as required by law. For uses and disclosures other than these purposes, your written authorization is required before sharing your health information. This includes sharing your health information with your spouse, relatives, employer, etc. This form allows you to authorize Independent Health to use or disclose your health information including HIV-related information to those individuals or entities you specify.

Please read before completing this form

- Incomplete authorizations will be considered invalid and will not be accepted. Incomplete authorizations will be returned. **An asterisk (*) is used to denote the required fields in this form.**
- 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.
- You may revoke this authorization in writing at any time by sending Independent Health a letter or calling Independent Health's Member Services Department at (716) 631-8701 or 1-800-501-3439, Monday – Friday, 8 a.m. – 8 p.m. Telecommunications Device for the Deaf (TDD): 711. Your revocation notice will not apply to actions taken by the requesting person/entity prior to the date we received your written request to revoke this authorization.

Send completed and signed authorization to:

Independent Health
P.O. Box 1642
Buffalo, NY 14231
Fax: (716) 631-1039
memberservice@servicing.independenthealth.com

If you need assistance completing this form, please contact:

Medicare Members

(716) 250-4401
1-800-665-1502
(TTY users can call 711)

All Other Members

Member Services Department
(716) 631-8701
1-800-501-3439

Authorization to Disclose Protected Health Information (PHI)

Section A: Member Information*

Name*:

Date of Birth*:

/ /

Member ID*:

_____ - ____

Section B: Authorized Individuals* (at least one individual is required)

Please list the individuals and/or entities that you are authorizing to view or receive your health information. If more space is required to list individuals or entities, please attach an additional page.

1.	Name*:	Relationship*:	Telephone Number*: ()
2.	Name:	Relationship:	Telephone Number: ()
3.	Name:	Relationship:	Telephone Number: ()

Section C: Information That Can Be Released (Please check one)*

If more space is needed to describe the information that can be released, please attach an additional page.

☐ All my health information maintained by Independent Health. By initialing below, I choose to include information regarding the following conditions in this authorization (see pg. 4 for additional information):

- _____ Alcohol and/or Substance Abuse
- _____ HIV-Related
- _____ Pregnancy / Reproductive
- _____ Mental Health
- _____ Sexually Transmitted Diseases
- _____ Genetic Testing

☐ Only the following specific health information (such as claims submitted by a specific provider or information related to one of the protected diagnoses listed above):

Section D: Scope of Authorization (Please check any that apply)*

The individuals in Section B may:

- ☐ Discuss verbally your health information with Independent Health.
- ☐ Inspect and obtain copies of your health information from Independent Health.
- ☐ Change your Primary Care Physician, phone number and address maintained by Independent Health.

Section E: Purpose and Time Period

Unless noted below, the authorized parties in Section B can obtain your health information upon their request and from the start date of your plan coverage with Independent Health.

☐ Purpose: _____

☐ Time Period: Only release health information concerning dates of service from (insert date) _____ to (insert date) _____.

Section F: Expiration

Unless noted below, this authorization will expire 90 days after termination of your enrollment, upon your death, in the case of a minor, when the named minor reaches the age of eighteen (18) years, or if Independent Health receives a letter canceling this authorization.

This authorization will expire:

☐ 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
- ☐ Surrogate decision maker appointed pursuant to Family Health Care Decisions Act (FHCDA)

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:	Relationship:	Telephone Number: ()
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Section H: Signature/Date*

Please read the following carefully before you sign, and refer to page 4 for additional information.

By signing this form, I understand the following: (1) if the entity authorized to receive my health information 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-related information, 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.

Signature of Member or Personal Representative

Date: _____

Send completed and signed authorization to:

Independent Health
P.O. Box 1642
Buffalo, NY 14231
Fax: (716) 631-1039
memberservice@servicing.independenthealth.com

Sensitive Information

- **Alcohol and Substance Abuse Information**

By initialing the appropriate box on this form, alcohol and substance abuse information can be provided to the individuals listed by you on this form. If information is disclosed from alcohol or substance abuse records protected by federal confidentiality rules (42 CFR Part 2), these rules prohibit the recipient 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 as otherwise permitted by these rules.

- **HIV-Related Information**

By initialing the appropriate box on this form, HIV-related information can be provided to the individuals listed by you on this form. HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York state law, HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; authorized agencies involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood; special court order; attorney assigned to represent a minor or by an executor or administrator of an estate (Public Health Law §2782). Under state law, anyone who illegally discloses HIV-related information may be punished by a fine of up to \$5,000 and a jail term of up to one year. However, some re-disclosures of medical and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

- **Pregnancy and Reproductive Information**

By initialing the appropriate box on this form, information relating to pregnancy and reproductive health can be provided to the individuals listed by you on this form. Information regarding pregnancy and reproductive health cannot be disclosed, even to a parent or guardian of a minor patient, without the specific authorization of the patient (Public Health Law §17).

- **Mental Health Information**

By initialing the appropriate box on this form, mental health information can be provided to the individuals listed by you on this form. Mental health information, including a patient's clinical records and information can be released, with your consent or the consent of someone authorized to act on your behalf, to those authorized agencies listed by you on this form who have a demonstrable need for such information provided such disclosure will not reasonably be expected to be detrimental to you or others (Mental Hygiene §33.13).

- **Sexually Transmitted Diseases**

By initialing the appropriate box on this form, information regarding sexually transmitted disease can be provided to the individuals listed by you on this form. Parents may access most of their child's medical records until the child turns 18, with the exception of information relating to the diagnosis and treatment of sexually transmitted disease (Public Health Law §17). Such information cannot be released to any party, including the child's parent or guardian, without the child's specific authorization.

- **Genetic Testing**

By initialing the appropriate box on this form, genetic testing information can be provided to the individuals listed by you on this form. Genetic testing information includes any information relating to laboratory tests of human DNA, chromosomes, genes or gene products to diagnose a predisposition to a genetic disease of disability in the individual or offspring (Civil Rights Law §79-l). Genetic testing information shall not be released without your specific consent with the exception of information released to a health insurer or health maintenance organization for the purpose of claims administration.

Independent Health is a Medicare Advantage organization with a Medicare contract offering HMO, HMO-SNP, HMO-POS and PPO plans. Enrollment in Independent Health depends on contract renewal.

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