



AUTHORIZATION TO SHARE MY PROTECTED HEALTH INFORMATION

Making HIPAA as Easy as 1, 2, 3 – and 4, 5, 6!

Five Letters That Protect Your Privacy: Your privacy has always been very important to us and the federal government recently created HIPAA laws to protect how and when your health care and personal information can be shared.

If you'd like us to share information about you with people or other organizations, please complete this form. This includes sharing information with a spouse, friend, or even a parent if you are over the age 18. Giving your consent to share your personal information is as easy as 1, 2, 3 – and 4, 5, 6 by completing the six sections of this brief form. For your convenience, you can use this form to authorize our disclosure of your information to more than one person. However, each person you identify will have the same access to your information. If you would like each person to access *different* information or to have access to your information for a *different* period of time, you'll need to complete separate forms for each individual or time period. A little extra paperwork, but protecting your privacy is worth a few minutes of your time! Please remember that to provide you with quality service, we will continue to communicate our payment activities in connection with your claims, your enrollment in our health plan or your eligibility for benefits to providers of care involved in your treatment.

Important Note: There are state and federal laws that contain special protections for certain conditions. These conditions are genetic testing, alcohol or substance abuse, mental health, abortion, sexually transmitted diseases and HIV/AIDS. If you would like us to share information with other people or organizations on one of these protected diagnoses, please clearly state this below in Step 2 in the second option regarding specific information. In order for us to release information about a minor regarding abortion, sexually transmitted diseases or substance abuse, the minor must complete the authorization - even to disclose information to a parent. If you would like to authorize us to release information regarding HIV/AIDS, a different form needs to be completed. We ask that you contact our office at the telephone number on your identification card, or visit our website for this form at:

www.univerahealthcare.com. Go to the *Members* area and click on *Print Forms*.

Your authorization is completely voluntary and you don't have to sign this form. We will not condition our payment activities in connection with your claims, your enrollment in our health plan or your eligibility for benefits on you giving this authorization. If additional forms are needed, you may copy this form, visit our Web site at www.univerahealthcare.com or contact our office at the telephone number listed on your identification card.

Please check here if you would like to authorize access to psychotherapy notes. If this box is checked, then this authorization cannot be used for another reason. If checked, steps two and three below can be skipped.

Please be sure to provide us with all of the following information.

Step 1: Tell Us Who You Are:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Member ID Number(s) as listed on your identification card(s): _____

Birth Date: _____/_____/_____

Step 2: Tell Us Why You'd Like Us to Share Your Information:

So Univera Healthcare can:

- Respond to all requests for confidential information about me made by the individual(s) or organization(s) I list below.
- Respond to requests for only the following specific information (such as claims submitted by a specific provider or information related to one of the protected diagnosis listed above)

Please specify: _____

- Respond to inquiries related to a specific date of service:

Please specify: _____

Step 3: Tell Us What Specific Information You'd Like Us to Share: Please list the specific protected health information you wish us to disclose. **Please check all that apply:**

- My claim information (e.g. status, type of service, diagnosis, provider, dates of service, etc.)
- My membership information (e.g. coverage information, enrollment dates, eligibility, address, dates of birth, etc.)
- My benefit information (e.g. benefits available, benefits used, contract limits, etc.)
- My medical records (e.g. physician or hospital records, case management, etc.)
- Other information (please specify): _____
- Please exclude the following information: _____

Step 4: Tell Us With Whom You'd Like Us to Share Your Information: Please list the person(s) and/or organization with whom you want us to share the information you described above. Please remember if you'd like us to share information with more than one person, the information to be disclosed and the expiration date must be the same for each person.

<u>Name/Organization</u>	<u>Address</u>
_____	_____
_____	_____
_____	_____

Step 5: Tell Us When You'd Like Us to Share Your Information:

Please share my protected health information during the time period(s) below:

- Until Univera Healthcare completes the activities outlined in section 2.

Until I send Univera Healthcare a form canceling my authorization.

From ____/____/____ through ____/____/____.

Step 6 (the last one!): Please Give Us Your Signature:

To give Univera Healthcare your consent to share the protected health information noted above, please print your name on the line below and then provide your signature and today's date.

I, (please print name here) _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I confirm my authorization for the use, request and release of my confidential member information as described in this form. I understand that I may cancel this authorization at any time by completing an authorization revocation form and sending it to the address below. I also understand that the revocation of this authorization will not take effect until Univera Healthcare receives my authorization cancellation form.

I understand that, if the person(s) or organization(s) I authorize to receive information described in this form is not a health plan, covered provider or health care clearinghouse subject to federal health information privacy laws, s/he may further disclose the information and it may no longer be protected by those laws.

Signature: _____

Date: _____

(Member or Personal Representative)

If this request is by a personal representative on behalf of our member, please give us the following information:

Personal Representative's Name: *(please print)* _____

Description of Personal Representative's Authority (a power of attorney, legal guardian or state executor):

Please note: personal representatives must provide legal proof of representation, such as power of attorney documentation.

Please complete and return this form to:

Univera Healthcare
P.O. Box 4839
Syracuse, NY 13221
FAX: 1-315-671-7079

PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS