Dear Current/Former Member:

Enclosed is the ***Authorization for Disclosure of Protected Health Information*** form you recently requested. Here are some helpful hints for use when completing the form:

- **Include your full name, date of birth, and complete Member ID number, in the corresponding fields on the first two lines of the form.**
- Your authorization to disclose your Protected Health Information (PHI) requires the name, address, and telephone number of the individual person you wish to have us disclose the information to. An authorization without a specific individual's name will be considered invalid.
- Please include the purpose and uses that your authorization permits, and check any and all applicable boxes for the PHI you authorize us to disclose to the identified recipient; if needed, utilize the 'Other' box and describe the specific PHI you authorize to be disclosed. Purposes commonly specified include disclosing information for payment purposes or disclosing information for the treatment of a specific health condition. If that section is left blank, Health Options will disclose all information you specified on the form as appropriate to disclose to the authorized individual.
- You must sign and date the form.
- Once complete, please return the form to us:

By Mail: Privacy Officer
Community Health Options
PO Box 1121
Mail Stop 100
Lewiston, ME 04243

Or, By Fax: Attn: Privacy Officer
(207) 402-3745

Thank you for choosing Community Health Options. Our Member Services team, at (855) 624-6463, is available Monday through Friday, 8am - 6pm, to answer any questions you have regarding the completion of this form.

Sincerely,

Member Services
Community Health Options

Authorization for Disclosure of Protected Health Information

Current/Former Member's Full Name_____

Current/Former Member's Date of Birth_____

Current/Former Member ID#:_____

This will authorize **Community Health Options (Health Options)** and its employees to disclose my Protected Health Information (PHI) to:

_____

Name of Authorized Representative **Address City/State/ZIP**

_____

Phone # **Fax #**

I authorize this disclosure for the following purposes and uses: _____

Disclosure may include the following PHI:

☐ Mental health information (excluding psychotherapy notes)

☐ Psychotherapy Notes Only (If applicable, no other information may be included in authorization)

☐ HIV records and information

- *I understand that authorizing the disclosure of HIV records and information could have adverse consequences, including the loss or denial of employment and other forms of discriminatory treatment, whether lawful or unlawful.*

☐ Substance abuse information (further re-disclosure prohibited or governed by 42 CFR Part 2)

☐ Genetic testing information

☐ Other (describe) _____

☐ All of my PHI including above

By signing below:

I intend this authorization to apply to disclosures of PHI that Health Options has received from other persons or entities. I authorize that subsequent disclosures of PHI within the scope of this authorization may be made pursuant to this same authorization.

I understand that I am entitled to a copy of this authorization.

I understand that this authorization may be revoked in writing and delivered to the Privacy Officer of Health Options at any time, although revocation will not be effective to the extent anyone has already relied on the authorization.

I understand that PHI used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I understand that Health Options shall not condition treatment, payment or enrollment in a health plan or eligibility for benefits on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.

Current Members: This authorization will expire 2 years from the date of the signature or when the policy is no longer active – whichever comes first.

If you prefer a shorter time in which this authorization is valid please indicate the date it would expire:_____. .

Former Members: This authorization will expire after 1 year from the date of the signature.

If you prefer a shorter time in which this authorization is valid please indicate the date it would expire:_____.

_____ _____

Date

Signature of current/former Member
(or their legally authorized representative)

_____

*Authority or relationship of authorized representative

Return to:

Privacy Officer, Community Health Options, Mail Stop 100, P.O. Box 1121, Lewiston, ME 04243 Fax: (207) 402-3745 Attn: Privacy Officer

NON-DISCRIMINATION NOTICE

Community Health Options complies with applicable Federal civil rights law and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le 1-855- 624-6463 (TTY/TDD: 711)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-624-6463 (TTY/TDD: 711)