Authorization for Disclosure of Protected Health Information (PHI) and Account Changes Form

Current or former Members may use this form to: (i) authorize Health Options and its employees to release PHI to a designated person; and (ii) designate an individual able to initiate limited account changes.

- Section I, you must complete all lines in this section and may only specify one person to whom the information may be disclosed to per form.
- In Section II, you can choose to release all information or just a limited amount. If you select the limited option, check the specific information you want disclosed.
- Section III, applies to sensitive information. You can leave it blank, release all, or choose specific topics. If you select specific topics, check them off on the form.
- In Section IIII, you can choose to designate an individual who can initiate limited changes to your account.
- Sign and date the form as instructed at the bottom of the form. If you have questions about how to fill out this form, call Member Services at the number on the back of your ID card.

Section I (Required)

_____

Current/Former Member's Full Name

_____ _____

Current/Former Member 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 only one person per form)

_____ _____

Name of Authorized Representative Phone#

_____

Address/City/State/ZIP

Section II (Required)

I authorize the disclosure of the following types of information by Health Options: (Check one box below)

☐ All my information. This can include health, diagnosis (name of illness or condition), claim, doctor, and other healthcare providers and financial information (like billing and banking). This does not include sensitive information unless it is approved in Section III below.

OR

☐ Only limited information may be released (check all circles below that apply to you).

O Appeals
O Benefits and coverage
O Claims and payment
O Diagnoses (name of illnesses or conditions) and procedures (treatment)
O Eligibility and enrollment
O Financial information
O Invoicing
O Medical records
O Doctors and hospitals
O Pre-certification and preauthorization (for treatment approvals)
O Referrals
O Treatments
O Dental
O Vision
O Pharmacy
O Other: _____

Section III (Optional)

I authorize the disclosure of the following types of sensitive information by Health Options: (check one box below only if it is applicable)

☐ All sensitive information

OR

☐ Specific information about topics (check all circles below that apply to you).

O Abortion
O Abuse (sexual/ physical/mental)
O Alcohol/substance use disorder*
O Genetic testing
O HIV or AIDS
O Maternity
O Sexually transmitted illness
O Mental Health (ex.) psychotherapy notes
O Other: _____

*I understand that my alcohol/substance use disorder records are protected under federal and state confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I understand that I cannot cancel this approval when this form has already been used to disclose information.

Section IV (Optional)

The authorized representative named in Section I is able to initiate the following account changes (check all boxes below that apply to you).

☐ PCP Changes
☐ Change paperless mail settings associated with my account
☐ Autopay payment method (card changes)
☐ Request a duplicate ID card be mailed (original lost or not received)
☐ Request that my Member Portal password be reset

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 according to this authorization.

I understand that:

- I am entitled to a copy of this authorization.
- I may revoke this authorization in writing delivered to Health Options' Privacy Officer at any time, although revocation will not be effective to the extent anyone has already relied on the authorization.
- PHI used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- 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 be valid for the duration the policy is active. 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 one (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: _____

_____

Signature of current/former Member is required (or their Legally Authorized Representative)** Date

_____

**Authority or relationship of authorized representative

Send us the completed form via email (preferred), postal mail or fax.

- Email to: Enrollment@HealthOptions.org
- Mail to: Community Health Options, Mail Stop 100, PO Box 1121, Lewiston, ME 04243
- Fax to: Community Health Options, 207-402-3745, Attn: Privacy Officer

CONFIDENTIALITY NOTICE: This communication was reviewed for compliance with applicable privacy standards prior to distribution. All parties sending, handling, or storing protected health information are obliged to meet relevant HIPAA standards. This communication is intended only for the use of the individual to which it is addressed. If you have received this communication in error, please notify Community Health Options immediately at (855) 624-6463. This communication and its information may be protected by federal and/or state privacy and confidentiality rules. You are hereby notified that any disclosure, dissemination, or copying of this communication or its information is prohibited unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law.