



Current or former Members may use this form to authorize Community Health Options and its employees to release PHI to a designated person, and to designate an individual to initiate limited account changes. If you have any questions, contact Member Services at (855) 624-6463.

Section I (Required)			
All fields must be completed and only specify one person to whom the information may be disclosed per form			
Current/Former Member's Full Name		Date of Birth	Member ID #
Name of Authorized Person		Phone Number	Relationship to Member
Address	City	State	Zip Code

Section II (Required)
Choose to release all information or a limited amount

I authorize the disclosure of the following types of information by Community Health Options (check only one box).

All my information. This can include health, diagnosis (name of illness or condition), claim, doctor, 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 (mark all below that apply).

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

Section III (Optional)
This section applies to sensitive information. You can leave it blank, release it all, or choose specific topics

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

All sensitive information.

OR

Specific information about topics (mark all below that apply).

- Abortion
- Abuse (sexual/physical/mental)
- Alcohol/substance user disorder*
- Genetic testing
- HIV or AIDS
- Maternity
- Sexually transmitted illness
- Mental health (psychotherapy notes)
- 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 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 can initiate the following account changes (mark all below that apply).

- 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 Community Health Options has received from other persons or entities. I authorize 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 Community 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.
- Community 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 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 one year after 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

Date

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

- Email to: enrollment@healthoptions.org
- Mail to: Community Health Options, 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.*