COMMUNITY Health Options™

Authorization for Disclosure of Protected Health Information (PHI)

Instructions: This form is to be completed by a current or former Member to authorize Health Options and its employees to release PHI to a designated person. Section I must be completed to be valid and Section II is optional. Please print clearly.

- You may only specify one person to whom the information may be disclosed per form.
- In Section I you can choose to release all information or just a limited amount. If you choose the limited option, be sure to check the specific information you want disclosed.
- Section II applies to sensitive information. You can leave it blank, release all, or choose specific topics. If you choose specific topics, make sure to check them off on the form.
- 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 (855) 624-6463.

Section I

_____

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

_____

Address/City/State/ZIP

_____ _____

Phone# | Fax#

I authorize the disclosure of the following types of information by Health Options: (Required, 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 II below.

OR

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

Authorization for Disclosure of Protected Health Information

- 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 II (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.

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 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 expire two (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 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 (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