ECHS Category - PHIA

Authorization for Release of Protected Health Information (PHI)

My health record is private and is known under the law as "Protected Health Information (PHI)."

By completing and signing this form, I, or my legal representative, agree to allow my health plan to share my PHI with the people or companies listed below. By health plan, I also mean the company's subsidiaries, affiliates, employees, agents and subcontractors. PLEASE COMPLETE ALL SECTIONS.

1. My information

My first name	Last name	Middle initial
My member ID number	My birth date *(MMDDYYYY)*	My phone number
My street		My city, state, ZIP code

2. My PHI can be shared with the following People or companies:

Person or company name	Phone number
Street	City, state and ZIP code
Person or company name	Phone number
Street	City, state and ZIP code

3. My Health Plan can share ONLY my records chosen below.

You must check any and all information that you want to be shared. This authorization cannot be used to share psychotherapy notes.

- ☐ Health (medical, dental, pharmacy, vision and flexible spending account information)
- ☐ Long term care ☐ Patient management records
- ☐ Substance use disorder (alcohol/drug) ☐ HIV/AIDS ☐ Sexually transmitted diseases
- ☐ Behavioral health/Mental health (but NOT psychotherapy notes).
- ☐ Other (please explain) _____

4. By signing this form I authorize my Health Plan to disclose information below for the following purpose.

Check one of the following options:

☐ At my request – no specific purpose ☐ Specific purpose: _____

5. This form will be valid for 1 year unless a shorter time period is listed below.

My authorization is valid from

_____ to _____

MM/DD/YYYY MM/DD/YYYY

6. By signing below, I understand and agree:

- My PHI that I agree to share may be sensitive. It may include diagnosis and treatment information. It may cover chronic diseases, behavioral health conditions and alcohol or drug abuse. It may cover communicable diseases, sexually transmitted diseases such as HIV/AIDS, and genetic marker information.
- Whoever gets my PHI may share it with others. That means federal or state privacy laws may no longer protect my PHI.
- I can get a copy of this authorization form that I have signed by sending a signed request using the address at the bottom of this form.
- My PHI information will not be released to the individual(s) or company(ies) named in Section 2 unless I sign this form.
- I can cancel or change my decision any time. I can do this by writing to my health plan, using the address at the bottom of this form.
- If I do cancel my permission, it will not affect actions taken by my health plan before getting my request.
- My ability to enroll won't change if I do not sign this form.
- My eligibility for benefits and services won't change if I do not sign this form.

ATTENTION:

My signature is required if any of the below apply:

- I am 18 years of age or older
- I am a minor under the age of 18 and I am either married or I am emancipated
- The information being disclosed pertains to drug or alcohol treatment
- The information being disclosed pertains to one of the following conditions and my state allows me to be treated even if my parents or legal guardian do not agree with my decision:
  - Mental health
  - Sexually transmitted disease (including HIV/AIDS)
  - Reproductive health (including contraception, prenatal care and abortion)
  - General medical and dental health

7. My signature or my legal representative's signature

Signature	Date
Print name	
If a legal representative signed this form, describe the relationship: (parent, legal guardian, Power of Attorney, personal representative)	

- If this request is being signed by the member's legal representative, you must provide legal documentation authorizing you to act on the member's behalf (legal guardianship, power of attorney, personal representative).
- If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

Please sign and return this completed form to:

HIPAA Member Rights Team
PO Box 14079
Lexington, KY 40512-4079

Or you can fax it to: **859-280-1272**