Authorization for the Release of Protected Health Information

Member Requests Only

I hereby authorize Peoples Health to disclose my protected health information (PHI) as described below.

Member name: ______________________ Member Number: ______________ Date of birth: ________

This person or entity is authorized to **receive** my PHI: ____

This authorization expires on the following **date** or **event** (must choose one of the following):

- ☐ Specific date (*mm/dd/yyyy*): ______________ ☐ Death
- ☐ When my Peoples Health plan coverage ends ☐ Other: ______________________________

This authorization is for the use or disclosure of protected health information for the following purpose: ____________________________________ If no purpose is provided, then the purpose of this authorization shall be deemed to be "at the request of the individual" whose name first appears above.

The information to be disclosed from my health record: ***(check all that apply)***

- ☐ Only information related to *(specify diagnosis, billing, injury, operations, special therapies, etc.)* ________
  ____
- ☐ Only the period of events from *(specify date range)* _______________ to _______________
- ☐ Entire record
- ☐ Other *(specify a topic, such as billing)* ____________________________________

Information on the following sensitive topics can be disclosed: ***(check all that apply)***

- ☐ Alcohol or drug abuse treatment or referral ☐ HIV or AIDS-related treatment
- ☐ Sexually transmitted diseases ☐ Mental health *(other than psychotherapy notes)*

YOUR RIGHTS UNDER THIS AUTHORIZATION

You have the right to revoke this authorization at any time by sending written notification to the Peoples Health Privacy Officer. Your refusal to sign this authorization will not affect your eligibility for benefits, ability to obtain treatment or to have that treatment paid for by a health plan offered by Peoples Health. Please note that if your PHI is disclosed to a person or entity that is not required to comply with federal or state privacy regulations, such information may be re-disclosed and would no longer be protected by federal or state law.

I certify that all the information provided is true and complete and that Peoples Health, its providers and workforce have the right to rely on the information provided.

____ ________________

Signature *(if signed by personal representative, please indicate authority to do so)* Authority *(optional)*

____ ________________

Printed Name Date

Mail form to the address at the bottom of the page.

For Internal Use

______________________________ ________________

Privacy Officer Signature Date

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