



Authorization to use or disclose protected health information

PURPOSE: This form authorizes HealthNow and its Business Associates to use and/or disclose Protected Health Information (PHI) for the individual and purposes outlined below and as permitted by the HIPAA Privacy Regulations.

INSTRUCTIONS: Please complete and/or check the box(es) in each section and where an explanation is requested, be as specific as possible as the information provided will be strictly followed. If all sections are not completed, this authorization may not be considered valid.

IMPORTANT INFORMATION PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Effect of Granting this Authorization – The PHI described below may be disclosed to and/or received by persons or organizations that are not subject to federal health information privacy laws. These persons or organizations may further disclose the PHI, and it may no longer be protected by federal health information privacy laws.

Right to Revoke – You may revoke this authorization at any time by giving written notice of revocation to the Contact Office listed on page 3. Revocation of this authorization will not affect any action previously taken by HealthNow or another entity, if applicable, in reliance on this authorization before written notice of revocation was received.

Restrictions on Psychotherapy Notes – If this is to authorize the disclosure or request authorization to disclose psychotherapy notes, **it must not be used as authorization for the use/disclosure of any other type of PHI.**

Restrictions on HIV and AIDS Information – **This authorization is not valid for and will not allow the release of any records containing HIV or AIDS information.** A separate authorization form [FORM 2(D)] is required to request the disclosure of this type of information. This form is available on the HealthNow web site.

Restrictions on Mental Health and Alcohol and Substance Abuse Information – **This authorization is not valid for and will not allow the release of any records containing mental health or alcohol and substance abuse information.** A separate authorization form [FORM 2(E)] is required to request the disclosure of this type of information. This form is available on the HealthNow web site.

Section A: Individual Whose PHI is to be released:

Name: _____ Date of Birth: _____

Address: _____

Identification Number: _____ Telephone: _____

Section B: Individual Requesting this information to be released (if different than above):

Name: _____

Address: _____

Telephone: _____

Authority as: Parent Legal Guardian Power of Attorney Executor

Other (explain) _____

Documentation supporting authority:

Enclosed On file with HealthNow

Section C: PHI Authorized to be Used and/or Disclosed (check all that apply):

Any information or PHI in connection with any claim or appeal for coverage or benefits

PHI related to a specific diagnosis date of service, provider of service, etc. (explain under 'Other')

Medical Records/Review Information

Contract Benefits/Policy Information

Billing/Premium Information

Eligibility/Biographical Information

Other: _____

Section D: Persons and/or organizations designated to receive the identified information.

Name: _____ Telephone: _____

Address: _____

Name: _____ Telephone: _____

Address: _____

Name: _____ Telephone: _____

Address: _____

Section E. Purpose(s) of the Authorization (check all that apply):

To authorize the identified persons and/or organizations to discuss orally with HealthNow the PHI indicated and as permitted by the HIPAA Privacy Regulations.

To authorize the identified persons and/or organizations to inspect and/or obtain copies of the PHI indicated as permitted by the HIPAA Privacy Regulations.

To authorize the identified persons and/or organizations the authority to make changes to and/or decisions regarding the PHI for the following as permitted by the HIPAA Privacy Regulations.

PCP Address Telephone Email

Other (explain): _____

Section F. Please Indicate the Period of Authorization:

IMPORTANT: If an effective date and/or termination date or event are not indicated, the authorization will be effective the date it is received by HealthNow and will terminate one year from that date.

Authorization Effective Date ____ / ____ / ____ Authorization Expiration Date ____ / ____ / ____

OR Authorization will expire on occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

One year after death of individual named in Section A, in order to resolve outstanding issues.

One year from termination of coverage for the individual named in Section A, in order to resolve outstanding issues.

Other (explain): _____

Section G. If you have questions, or need additional information or assistance in completing this authorization, please call the Customer Service telephone number on the back of your identification card or write the Contact Office listed below.

Contact Office: **Privacy Department**
Address: **PO Box 15013**
Albany, New York 12212

Contact Office: **Privacy Department**
Address: **PO Box 80**
Buffalo, New York 14240

Signature:

I, _____, have had full opportunity to read and consider this authorization. I understand that, by signing this form, I am authorizing the use and/or disclosure of the Protected Health Information, as described in this form.

Signature: _____

Print Name: _____

Date: _____