AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. Please fill in the Identifying data carefully and completely, otherwise the form will not be considered valid. Use the instruction sheet to guide you.

Member Name: _____

Home Address: _____

Telephone Number: _____ Date of Birth: _____

2. Recipient of Information:

Name: LIFEPlan CCO_____
Address: _____
Telephone: _____ Email Address: _____

3. Purpose of the Authorization:

_____ At my request. OR

For the following purposes: _____

4. Individuals/ Providers/ Entities Authorized to Use or Receive Information:

Name	Address

Initial below to allow information or records related to any of the following to be shared with the authorized person. Release of the following information requires specific authorization.

_____ Alcohol abuse/substance abuse
_____ Behavioral health (excluding psychotherapy notes)
_____ Genetic markers
_____ HIV/AIDS
_____ Sexually transmitted disease

5. Term of Authorization:

Authorization should expire (end) on ____/____/_____ (month/day/year) OR

Upon the following event: _____

NOTE: I understand that if I fail to specify an expiration (end) date or event, the authorization will remain in effect until I revoke (cancel) it in writing or no longer receive services from LIFEPlan.

6. Conditions of Authorization: I understand that:

- The information disclosed under this authorization may be further disclosed by certain recipients and no longer protected by state and federal privacy laws.
- I have the right to revoke (cancel) this authorization at any time, and that the revocation (cancellation) must be in writing and sent to LIFEPlan CCO 258 Genesee St. Mezzanine, Utica, NY 13502.
- Any revocation (cancellation) will become effective as soon as receives my written notice. I understand that the revocation will not affect any action taken by LIFEPlan CCO in reliance on the authorization prior to receiving my written notice of revocation.
- I may refuse to sign this authorization. LIFEPlan CCO will not condition my enrollment on my provision of the authorization. LIFEPlan may not condition payment of a claim on my provision of this authorization.
- If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.

7. Signature Required:

I have read and understood the terms of this authorization. I have also had a chance to ask questions about how my health information will be used and disclosed. By signing this authorization, I am affirming that to the best of my knowledge all information provided on this form is complete, accurate and consistent with my directions. I hereby provide my consent to the use and disclosure of my health information in the manner described in this form.

Signature _____ Date _____

NOTE: The signature of the individual or his or her personal representative (someone who has legal authority to act on the member's behalf) is necessary. A parent must sign for a minor dependent child.

Signature of Personal Representative _____ Date _____

_____ Parent _____ Legal Guardian* _____ Other* _____

*Provide documentation supporting your legal authority to act on the Individual's behalf.

Office Use Only – Staff Initials: _____Date Received: _____ Completed: _____