Formerly Known as HMA

PHI Release Authorization

Authorization for Release of Protected Health Information (PHI)

Member Instructions: This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows Verdegard Administrators, LLC to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to Verdegard Administrators, LLC. Revoking this authorization will not affect any action taken before receipt of your written request.

Section 1: Member Information (Individual whose information will be released)

Group Name:		Member ID Number:	
First Name:	Last Name:		Date of Birth:
Address:	City:	State:	Zip Code:
Phone:		Email:	

Section 2: Authorization

☐ I understand that my health record is private and is known under the law as "Protected Health Information (PHI)". I authorize Verdegard Administrators, LLC to release my PHI as described below.

Section 3: Recipient Information (Individual or organization that will receive the information)

Name (Person or Organization):			
Address:	City:	State:	Zip Code:
Phone:		Email:	

Section 4: Reason and Description of the Information Released

Reason for Release:

(Please check all that apply)

☐ Any information requested. *

☐ Health information (this includes medical, dental, pharmacy, vision, and flexible spending account). *

☐ Psychotherapy Notes: Federal law requires a separate authorization to use or release psychotherapy notes. If you check this box, you must complete another form to authorize the release of any of PHI.

☐ All information related to the provision of and payment for my health care benefits or services. *

☐ Specific Information: (Please describe) * ____
Examples: The claim related to my service on (date); Appeal information related to my claim on (date)

☐ **EUTF Supplemental Medical & Prescription Drug Plan** (Only)
For Dependents: To release personal health information (PHI) or to have reimbursement checks issued directly to the plan subscriber, please initial below. This is not necessary for minors under the age of 18.

Please Initial: ___________

***Please Note:** Some State law requires that you give specific permission to release certain information.

I understand that the above information to be disclosed under this authorization may contain information about HIV, AIDS diagnosis/treatment, mental health diagnosis/treatment, alcohol/drug diagnosis/treatment, developmental disability, and/or abuse, and I expressly authorize the disclosure of such information unless otherwise specifically indicated below:

<u>**DO NOT**</u> disclose the following information:

☐ **Genetic Information** ☐ **HIV / AIDS** ☐ **Substance/Alcohol Abuse** ☐ **Mental/Behavioral Health**

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Section 5: Expiration

This authorization will expire (Check ONLY ONE box):

- ☐ When I revoke this authorization *
- ☐ Upon the following date, event, or condition *:

Please Note: This authorization will terminate on the earliest of the events listed above or 180 days after termination of coverage. Some State laws require that this Authorization to Release PHI automatically expire within a set timeframe.
(For example: Minnesota = 12 months, Montana = 24 months).

* Verdegard Administrators, LLC must be notified in writing of the event/condition to cancel or revoke this authorization.

Section 6: Approval (Please check all boxes to indicate you fully understand)

- ☐ I understand that this authorization to release information is voluntary and is not a condition of enrollment in this Health Plan, eligibility for benefits, or payment of claims.
- ☐ I understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws.
- ☐ I understand that if a request for copies of claims/encounter information from the individual or company I have authorized above is received, then a reasonable fee may be charged (except when prohibited by law) to defray copying and mailing costs.
- ☐ I understand I can receive a copy of this authorization form that I have signed by submitting a request in writing.
- ☐ I understand that I may cancel or change this authorization at any time by providing notice in writing. I further understand that revoking this authorization will not have any effect on actions that took place before getting my request as received.
- ☐ Any facsimile or photocopy of this authorization shall authorize Verdegard Administrators, LLC to disclose the information requested herein. This authorization shall be effective as of the date of execution set forth below and remain in effect for a period stipulated, but not to exceed any period set by State law.

Section 7: Member Signature

By signing below, I authorize the release of my Protected Health Information (PHI) as described above

Signature	**Print Name**	**Date**