MERITAIN HEALTH

Authorization for Release of Protected Health Information (PHI)

I hereby authorize Meritain Health and any of its parents, subsidiaries and affiliates, and their respective employees, agents and subcontractors, to disclose PHI concerning the plan member identified below.

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY.

Please submit a separate Authorization for Release of Protected Health Information (PHI) for each plan member for whom Meritain Health is being requested to disclose PHI to a third party. If both sides of this form are not completed, as applicable, Meritain Health will be unable to process your request. Incomplete authorization requests will be returned.

Please print all responses

1. Member Information				
Last Name		First Name		Middle Initial
ID Number	Group Number or Group Name	Birth Date *(MM/DD/YYYY)*	Phone Number *(Including Area Code)*	
Street Address		City	State	Zip Code

2. Employee Information *(Please complete this section if the employee is not the member whose records are being requested.)*				
Last Name		First Name		Middle Initial
ID Number	Group Number or Group Name	Birth Date *(MM/DD/YYYY)*	Phone Number *(Including Area Code)*	
Street Address		City	State	Zip Code

3. I authorize the individual(s) or company(ies) identified below to receive PHI pertaining to the member identified in Section 1 above.*			
Individual or Company Authorized to Receive PHI		Phone Number *(Including Area Code)*	
Street Address	City	State	Zip Code
Individual or Company Authorized to Receive PHI		Phone Number *(Including Area Code)*	
Street Address	City	State	Zip Code
Individual or Company Authorized to Receive PHI		Phone Number *(Including Area Code)*	
Street Address	City	State	Zip Code

4. Purpose(s) for this Authorization

The purpose of this authorization is to permit disclosure of any and all requests for PHI, as well as information pertaining to disability and life insurance products, to the individual(s) or company(ies) named in Section 3 above. NOTE: This form cannot be used to authorize release of psychotherapy notes.

If you prefer to authorize disclosure of only selected categories of information, please indicate below which types of information may be disclosed.

❑ Health (this includes medical, dental, pharmacy, vision, and flexible spending account information)
❑ Behavioral Health (e.g. mental health, drug and alcohol abuse treatment, but not psychotherapy notes)
❑ Disability ❑ Life Benefits

This authorization will be in effect for one year from the date signed, unless you indicate a shorter period below.

_____ through _____
MM/DD/YYYY *MM/DD/YYYY*

***NOTICE TO RECIPIENT(S) OF INFORMATION (Section 3 above):**
Information disclosed to you pertaining to certain conditions, such as treatment for alcohol or drug abuse, HIV/AIDS and other sexually transmitted diseases, behavioral health, and genetic marker information is protected by various federal and state laws which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by such laws. Any unauthorized further disclosure in violation of state or federal law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient consent for release of these types of information. The federal rule at 42 CFR Part 2 restricts use of the information disclosed to criminally investigate or prosecute any alcohol or drug abuse patient.

4. Purpose(s) for this Authorization (continued)

This authorization will apply to all PHI maintained by Meritain Health, unless you specify certain categories below.

Description of the information to be released or disclosed: *(check all that are appropriate)*

❑ Application or enrollment information ❑ Claim status ❑ Claim records ❑ Patient management records

❑ Other: *(please specify)* _____

5. IMPORTANT: Your signature below means that you understand and agree to the following

- The PHI disclosed pursuant to this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, sexually transmitted diseases, HIV/AIDS, and/or genetic marker information. These records will be included in the information we will make available to the individual(s) or company(ies) identified in Section 3 above.
- Information disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy regulations. ***Oklahoma Residents:*** You may have additional protections under Section 1-502.2 of the Oklahoma Statutes if the type of information to be released relates to HIV/AIDS and/or sexually transmitted disease information.
- If we receive requests for copies of claims and encounter information from the individual or company you have named in Section 3, we may charge a reasonable fee (except where prohibited by law) to defray our copying and mailing costs.
- Your ability to enroll in a Meritain Health plan, and your eligibility for benefits and payment for services, will not be affected if you do not sign this form. (However, without your signature, your request to release information to the individual(s) named in Section 3 above will not be honored.)
- You may receive a copy of this signed form if you ask for it by writing to the address listed at the bottom of this page.
- You may revoke this authorization at any time by notifying Meritain Health in writing at the address below. Revoking this authorization will not have any effect on actions that Meritain Health took in reliance on the authorization before we received the notification.

6. Signature of Member or Member's Legal Representative

Minors must sign this form below if: ***(check applicable box)***

1. ❑ The minor is married or emancipated **or,**
2. ❑ The information being authorized for release pertains to drug or alcohol treatment **or,**
3. ❑ The information authorized for release pertains to one of the following conditions ***and*** applicable state law permits the minor to receive treatment for these conditions without consent of parent/legal guardian:
   a) Mental health
   b) Sexually transmitted diseases (including HIV/AIDS)
   c) Reproductive health (including contraception, prenatal care and abortion)
   d) General medical and dental health

All others must sign this form below as: ***(check applicable box)***

4. ❑ The member or member's legal representative **or,**
5. ❑ The parent/legal guardian of the emancipated minor, unless minor has signed at left, box 2 has been checked, and state law requires the signature of parent/legal guardian for drug and alcohol treatment
6. ❑ The parent/legal guardian of the unemancipated minor, unless minor has signed at left ***and*** box 3 at left has been checked.

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

If the person signing this Authorization is not the member, describe relationship to the member (i.e. Parent/Legal Guardian, Legal Representative):

If this authorization is being signed by the member's legal representative, you must furnish a copy of the healthcare power of attorney, or other relevant document authorizing you to act on the member's behalf.

Complete and send to:
Meritain Health
Attn: HIPAA Compliance Officer
P.O. Box 1671
Amherst, NY 14226-7671
Fax: 1. 716.319.5589