



# Authorization for Release of Health Information

Member's name/Person granting access \_\_\_\_\_

Date of birth      /      /           Member or subscriber ID# \_\_\_\_\_  
MM      DD      YYYY

Member's street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

### I understand and agree that:

- This authorization is voluntary.
- My health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information.
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form.
- My health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations.
- This authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying EmblemHealth and UnitedHealthcare and its affiliates in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

### Who may receive and disclose my information:

I authorize EmblemHealth and UnitedHealthcare and its affiliates to receive from or disclose my individually identifiable health information to the following person(s) or organization(s):

Full name of person(s) or organization(s) \_\_\_\_\_

Full address of person(s) or organization(s) \_\_\_\_\_

### Description of individually identifiable health information to be received or disclosed

(check appropriate type(s) of information):

- |   |  |
|---|--|
| <input type="checkbox"/> All                  | <input type="checkbox"/> Treatment plan(s) |
| <input type="checkbox"/> Claims               | <input type="checkbox"/> Progress reports  |
| <input type="checkbox"/> Eligibility/benefits | <input type="checkbox"/> Attendance only   |

Information used to make benefit determinations

All pertinent information NYCE PPO deems appropriate for the purpose checked below

Other (describe): \_\_\_\_\_

**The purpose of this authorization is** (check all that apply):

To allow the appropriate management of treatment, services, and/or coverage under the member's benefit plan.

Benefit management

Administration of a worker's compensation claim

Claims administration/payment

Administration of a disability claim

Employer mandated treatment referral

Subpoena or other legal process

Other (describe):

CARE programs

**The dates of records to be disclosed:**

From     /    /     To     /    /      
MM DD YYYY MM DD YYYY

**The member or member's representative must complete the rest of this form:**

I understand that this authorization will expire:

On     /    /      
MM DD YYYY

Signature of member (Required) \_\_\_\_\_ Date     /    /      
MM DD YYYY

Witness signature (For Illinois residents only) \_\_\_\_\_ Date     /    /      
MM DD YYYY

**Please note:** If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the member.

Signature of member's representative \_\_\_\_\_ Date     /    /      
MM DD YYYY

Print name \_\_\_\_\_ Phone number \_\_\_\_\_ - \_\_\_\_\_

Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Signature of minor member \_\_\_\_\_ Relationship to member \_\_\_\_\_

Description of representative's authority \_\_\_\_\_

Please return the completed form to:

**NYCE PPO Plan, P.O. Box 21534, Eagan, MN 55121** or Fax: **888-742-4179**

**For California and Georgia residents only**

I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it.

**Please maintain a copy of this document for your records.**