MENTAL HEALTH, ALCOHOLISM and/or SUBSTANCE ABUSE AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PROTECTED HEALTH INFORMATION (PHI)

IMPORTANT INFORMATION

CONFIDENTIAL PHI RECORDS SENSITIVE IN NATURE

Certain Federal and State Privacy laws require your express permission before we may discuss/release PHI to your relatives, friends, employer, etc. This authorization is required in order to document your intent and to identify the person(s) who has your permission to contact us on your behalf ("authorized person") for the reasons mentioned below.

In most instances, your authorization is not required before we may share your PHI with health care providers (e.g. physicians, hospitals, etc.) involved in your treatment or payment for your treatment. This exception is to ensure uninterrupted business operations such as timely submission and processing of your claims. *Therefore, it is NOT necessary to name your health care providers as authorized persons.*

This authorization is solely for release of PHI related to mental health, alcoholism, and/or substance abuse treatment.

*This authorization allows an Authorized Person(s) access to PHI for purposes such as checking claims status, policy benefits, pre-authorization procedures, etc. To authorize the release of records **not** related to mental health, alcoholism, and/or substance abuse a 2A (Authorization to Use or Disclose PHI) form must be completed.*

CONTACT INFORMATION

PLEASE RETURN THIS AUTHORIZATION FORM TO THE APPROPRIATE ADDRESS LISTED BELOW

If you have any questions or need assistance in completing this form, please call the Customer Service telephone number on the back of your identification card or write to:

Privacy Department
PO Box 15013, Albany, NY 12212

Privacy Department
PO Box 80, Buffalo, NY 14240

ALL SECTIONS ON BOTH SIDES OF THIS AUTHORIZATION MUST BE COMPLETED

PART 1 – HEALTH PLAN MEMBER (PATIENT) WHOSE PHI WILL BE DISCLOSED

PRINT the following information regarding the specific Health Plan member (patient) to whom this authorization applies:

Member Name: _____ **Date of Birth:** _____

Address: _____

Member ID#: _____ **Telephone:** (____) _____

PART 2 – ENTITY/ORGANIZATION AUTHORIZED TO MAKE THE DISCLOSURE

PRINT the name of the Health Plan (on the identification card of the member named in Part 1) that is authorized to disclose PHI as specified in this authorization:

Health Plan Name: _____

PART 3 – PHI THAT MAY BE DISCLOSED

This authorization permits the Health Plan named in Part 2 to disclose PHI in connection with any claim or appeal for coverage or benefits for (***CHECK ALL THAT APPLY***):

☐ **Mental Health** ☐ **Alcoholism** ☐ **Substance Abuse**

Disclosure of these records should be for the following dates or date range (if no dates are specified, **all** records maintained by the Health Plan and related to the issue checked here may be released): _____

PART 4 – AUTHORIZED PERSON(S) TO WHOM THE HEALTH PLAN MAY DISCLOSE PHI

PRINT the following information regarding the specific individual(s)/organization(s) to whom the Health Plan may disclose the PHI identified in Part 3:

Name: _____ **Relationship:** _____
City/State/Zip: _____ **Telephone:** (___) _____

Name: _____ **Relationship:** _____
City/State/Zip: _____ **Telephone:** (___) _____

Name: _____ **Relationship:** _____
City/State/Zip: _____ **Telephone:** (___) _____

PART 5 – AUTHORIZED PERSON(S) LEVEL OF AUTHORITY

Indicate the level of authority the Authorized Person(s) may have. The first choice is the default selection. If nothing else is marked, the Health Plan **will only allow** the Authorized Person(s) to discuss the PHI in person or via phone.

The Authorized Person(s) may take the following action(s) in regard to the PHI checked in Part 3:

- **X** **Discuss** the PHI in person or via phone (he/she is **not** entitled to copies of the PHI)
- ___ **Receive copies** of the PHI (e.g., explanation of benefits, claims history reports, etc.)
- ___ **Any actions** the member/patient named in Part 1 is permitted to take

PART 6 – EXPIRATION DATE AND PREVIOUSLY SUBMITTED AUTHORIZATIONS

Choose an authorization expiration date below and indicate whether this authorization will replace any already on file with the Health Plan. This authorization **must** have a **specific** expiration date/event. 'Indefinite', 'ongoing', 'forever', 'upon death', etc. are not considered specific expiration dates/events and cannot be honored.

1. This authorization **will expire** in (**check one**): _____ One (1) year _____ Three (3) years _____ Five (5) years from the date received by the Health Plan **OR** on expiration of the following (e.g. research study): _____
2. If the information in this authorization is to be added to an authorization previously sent to the Health Plan, the member's/patient's initials must be provided here _____. Otherwise all previous authorizations (for the same type of PHI) on file will be voided and the information replaced with the information in this authorization.

If an expiration date is not specified, this authorization will expire one (1) year from the date it is received.

PART 7 – STATEMENT OF UNDERSTANDING AND SIGNATURE - READ CAREFULLY

1. Signing this form attests to all information given above and that you are authorizing the use/release of the PHI as above;
2. This authorization is voluntary and not a condition of enrollment, eligibility, or claim payment;
3. The Authorized Person(s) may not be subject to federal/state privacy laws and they may further release the PHI;
4. You may revoke this authorization at any time by sending written notice to the Health Plan at the address on the reverse of this form. Your revocation will not affect any action previously taken in reliance on this authorization **prior** to the Health Plan's receipt of your revocation.

SIGNATURE OF MEMBER/PATIENT NAMED IN PART 1:

Print Name: _____ **Relationship to Member:** _____

Signature: _____ **Date:** _____