AUTHORIZATION FOR DISCLOSURE OF **PERSONAL HEALTH INFORMATION**

Instructions: By completing this form, I do hereby authorize my health care providers and their applicable business associates to disclose the following Protected Healthy Information ("PHI") pertaining to me: enrollment, claims, payment and managed care information, to Health Advocate, Inc. for the purpose of administering the Health Advocate program, including but not limited to assistance in my quest to obtain health care services and approval or payment for health care services. I understand I may exclude the release of certain information under this agreement. Accordingly, I wish to exclude the following information_____

_____.

I understand I am not required to authorize Health Advocate to have access to my PHI and that I can refuse to sign this authorization. I understand that by refusing to sign this authorization I will not be able to participate in the services offered by Health Advocate.

Name_____ _____ _____
Last First MI

Address _____ _____ _____ _____
Street (Apt #) City State Zip

Home Telephone: (_____) _____ **Work Telephone** (_____) _____

SSN: _____ **Date of Birth**_____ **E-Mail Address:** _____

The Morlock Foundation

Sponsoring Organization: _____

Health Insurance Carrier: _____**Group #**_____

Plan Type: HMO POS PPO INDEMNITY Member #:_____

I understand that Health Advocate provides administrative and Informational services only and does not provide health insurance or medical services nor does it recommend treatment. Consequently, independent health care practitioners, who are not employees or agents of Health Advocate, will provide all my medical services.

I understand that I may revoke this authorization at any time by given written notice of my revocation to Health Advocate's Privacy Officer at the above address. I understand that revocation of this authorization will not affect any action that Health Advocate or other parties took in reliance on this authorization before it received my written notice of revocation.

I understand that unless otherwise revoked, this authorization will commence on the date indicated below and will expire on the following date, event or circumstance:

_____
_____. If I fail to specify, this authorization will expire in twelve months.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and that the information may not be protected by federal health information privacy laws.

Signature_____ **Date**_____

_____ Date: _____
(Personal Representative: Include a description of authority to act for the patient)
YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION FORM AFTER YOU SIGN IT.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)
(INSTRUCTIONS AND IMPORTANT INFORMATION ON REVERSE)

PART 1
Member Name:_____ Date of Birth:_____

Address:_____

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

I authorize _____ to release my PHI as indicated below to the person(s)/entity (ies) named in Part 2.
(Name of Health Plan on identification card)

PART 2
Name:_____Relationship:_____

Address:_____Telephone:(____)_____

Name:_____Relationship:_____

Address:_____Telephone:(____)_____

PART 3
___ Any information or PHI in connection with any claim or appeal for coverage or benefits, including but not limited to:

- Benefits, premiums, eligibility,deductions,etc
- Address or telephone number date of birth, etc.
- Medical records, hospital/prescription pre-authorizations, referrals, etc.

___ Other/special instructions:_____

PART 4
X The Authorized Person(s) may **discuss** my PHI in person, writing or via phone.
X The Authorized Person(s) may **discuss and receive copies** of my PHI (e.g. explanation of benefits, etc.).
X The Authorized Person(s) may **discuss, receive copies of, and make changes to** my PHI (e.g. PCP changes, address changes, etc.)
__ The Authorized Person(s) may do **anything** I am permitted to do.

PART 5
1. My authorization is voluntary and not a condition of enrollment, eligibility or claim payment.
2. The Authorized Person(s) may not be subject to federal/state privacy laws and they may further release my PHI.
3. I may revoke this authorization at any time by sending written notice, however, revocation will not affect any action previously taken in reliance on this authorization prior to Health Plan's receipt of my revocation.
4. This authorization replaces any HIPAA authorizations previously sent to Health Plan, unless checked here_____.
5. 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_____.

See next page for important information regarding expiration date and previously submitted authorizations.

PART 6
Print Name_____Relationship_____

Signature_____Date_____

The Health Insurance Portability and Accountability Act (HIPAA), effective April 14, 2003, requires your express permission before we may discuss/release your protected health information 9PHI) to your relatives, friends, employer, etc. This authorization is needed to document your intent and to identify the person(s) who have your permission to contact us on your behalf ("authorized person") for claims status, benefit information, and/or other matters pertaining to your insurance coverage.

In most instances, HIPAA does not require your authorization before we may share you 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 for medical benefits. Therefore, it is NOT necessary to name your health care providers as authorized persons.

- Sensitive information/ diagnoses

  Do NOT use this form to request the release of HIV/AIDS information, mental health, and alcohol or substance abuse information. The required forms are 2(d) and 2(e) respectively, which are available on line or by contacting Customer Service. If you are using this form to authorize the release of psychotherapy notes, it must ONLY be used for psychotherapy notes. You MUST use a separate 2(a) form to authorize the release of any other PHI.

- Part 1: This section should name the member of the Health Plan whose PHI will be shared with and/or disclosed to the authorized person(s).
- Part 2: This section should name the authorized person(s) such as a spouse or child who will be contacting the Health Plan to discuss the member's PHI.
- Part 3: This section should indicate the specific PHI of the member that the Health Plan may share with and/or disclose to the authorized person(s)
- Part 4: This section is to identify how much authority you are giving the authorized person(s) to access and/or change you PHI. The default selection is marked with an "X". Mark any additional selections that apply.
- Part 5: Read this section carefully. Signing this form attests to all statements made in this section. IMPORTANT: (a) If the information is to be added to an authorization previously sent to the Health Plan, a checkmark must be made, otherwise all previous information will be voided; (b) An indefinite, ongoing or non-expiring authorization will not be considered valid. This authorization will expire one (1) year from the date it was received if an expiration date is not specific.
- Part 6: The member's signature is required. If the member is incapable of signing due to illness, injury or death, a personal representative (see below) may sign on the member's behalf. A personal representative (PR) such as the parent of a minor child, power of attorney or executor, may sign his or her name in the member's stead. The legal documents proving the authority of the PR to act for the member MUST be attached otherwise the PR's signature and this authorization will NOT be honored.
- Complete ALL sections

  This authorization will ONLY be considered valid if ALL sections are fully completed.

PLEASE RETURN YOUR AUTHORIZATION FORM(S) TO THE ADDRESS LISTED BELOW

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

Privacy Department
PO Box 15013, Albany NY 12212

Privacy Department
PO Box 80, Buffalo NY 14240

The Morlock Foundation
2323 Main Street
Buffalo, NY 14214
716-842-1300 or 716-240-3584