AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

By completing this form, you are authorizing YourCare Health Plan to use or disclose your protected health information, as defined by law, for the purpose stated below.

For minors (members under the age of 18):

- Until a child reaches age 18, parents may access *most* of their child's health information without getting the child's permission and a form is not required.
- Regardless of the child's age, parents cannot have access to health information, including claim payment information, relating to sexual activity, abortion, drugs and/or alcohol use, HIV/AIDS, or mental health unless the child specifically authorizes the release of such information. In these cases, the child must complete this form.

FORM INSTRUCTIONS

Important: The instructions below explain each numbered section of the authorization form. Please refer to them as you complete the form. If you have additional questions, please contact Member Services at 1-800-683-3781.

SECTIONS

1 Member Information: Fill in member data carefully and completely.

2 Recipient of Information: Tell us to whom you are asking us to release the information to.

3 Purpose of the Authorization: Check the box that applies and add any other information that we may need to know in order to disclose your information.

4 Information to Be Disclosed: Tell us which information you are authorizing YourCare to disclose by checking the appropriate box. If you want only specific information shared, tell us what type of information you would like us to disclose. We will not share certain types of information (such as behavioral health and HIV/AIDS information) unless specific authorizations are given or otherwise permitted or requested by law. Initial in the blanks to release any of this information. ***Note:*** YourCare Health Plan works with Beacon Health Options to provide Mental Health and Chemical Dependence services that include Alcohol and/or Substance Use services.

5 Term of Authorization: How long should YourCare Health Plan continue to share your protected health information? Please check the first box ***or*** check the second box and provide and end date or specify an event.

6 Conditions of Authorization: Please read this section all the way through.

7 Signature Required: Sign and date on the line provided to complete this authorization. If a personal representative (someone with legal authority to act on the member's behalf) is signing this authorization, check the appropriate box, explain your relationship to the member and provide documentation of legal authority to act on the member's behalf.

AUTHORIZATION TO SHARE MY PROTECTED HEALTH INFORMATION (PHI)

Please fill in member data carefully and completely, otherwise the form will not be considered valid. Use the instruction sheet to guide you. Please complete and return this form to: YourCare Health Plan, PO Box 240, Pittsford NY 14534 or FAX: 585-242-6212.

1 Member Information:

Member ID #: _____

Member Name: _____

Home Address: _____

Home Telephone Number: _____ Date of Birth: _____

2 Recipient (Person) We Are Sharing Your Information With:

Name:_____

Address: _____

Telephone: _____ Relationship: _____

3 Reason for Sharing Your Information:

☐ At my request

OR

☐ For the following purpose(s): _____

4 Information to Be Shared:

I authorize YourCare to disclose or discuss (*check one or both)* my protected health information as follows:

☐ All clinical, claims, billing, benefit or coverage information

OR

☐ Certain information only. Please list: _____

_____

Release of information regarding the following requires specific authorization. Only if you put your initials next to these items can YourCare disclose or discuss this health information with your appointed person.

_____ HIV/AIDS related information

_____ Alcohol abuse/substance abuse *(note any limitations above)*

_____ Behavioral/Mental health *(except psychotherapy notes)*

_____ Genetic testing

_____ Abortion

_____ Sexually transmitted disease

☐ **By checking this box, I am also allowing Beacon Health Options to disclose or discuss the above initialed information with my appointed person.**

5 Please share my protected health information during the time frame below:

☐ Until I cancel this authorization in writing

OR

☐ Upon the following event or end date: _____

6 Conditions of Authorization:

I understand that:

- The information disclosed under this authorization may be further disclosed by the person I am authorizing to have access to my information, in which case it may no longer be protected by state and federal privacy laws.
- I have the right to cancel this authorization at any time, except to the extent that YourCare has already acted based on this authorization. Any cancellation must be in writing and sent to the address noted on this form
- Any cancellation will become effective as soon as YourCare receives my written notice.
- If I am authorizing the release of alcohol or drug treatment, or mental health treatment information, the person I am authorizing to have access to my information is not allowed to share such information or use the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law.
- I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065.
- I understand that signing this form is voluntary. My treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing of this form.

7 Signature Required:

I have read and understood the terms of this authorization. By signing below, I am giving YourCare Health Plan authorization to share my protected health information as noted above.

NOTE: The signature of the member or his or her personal representative (someone who has legal authority to act on the member's behalf) is necessary.

Print Name of Member:_____

Signature of Member_____Date _____

Print Name of Personal Representative:_____

Signature of Personal Representative_____Date_____

Check One: ☐ Legal Guardian***** ☐ Power of Attorney***** ☐ Other***** _____

***Provide documentation supporting your legal authority to act on the member's behalf such as copy of health care proxy, copy of court order document, or copy of power of attorney form.**