

## Authorization to Use and Disclose Protected Health Information

### FORM INSTRUCTIONS

**Important: Please refer to the instructions below as you complete each corresponding section of the form.**

#### SECTION

**1**

**Member Information:** Please provide the information requested to ensure that the correct member's health information is disclosed.

#### SECTION

**2**

**Information to be Disclosed:** Please specify which information you are authorizing HIP to disclose by checking the appropriate box.

#### SECTION

**3**

**Recipient of Information:** To whom is HIP allowed to disclose this information? Please name the recipient(s) and provide their address(es).

#### SECTION

**4**

**Reason for Disclosure:** Please state the reason for disclosure by checking "At my request" or "For the following purposes." If you check "For the following purposes," indicate what they are.

#### SECTION

**5**

**Term of Authorization:** For how long are you authorizing HIP to release this information? Please check the first box and fill in the day, month and year that this authorization should remain in effect, or check the second box, which will cause your authorization to stay in effect for no more than six years.

#### SECTION

**6**

**Signature Required:** Please read the section titled "Conditions of Authorization" above number 6 on the form, then sign and date on the line provided.

#### SECTION

**7**

**Description of Authority:** If a personal representative is signing this authorization, please check the appropriate box for your relationship to the member.

# HIP\* AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

This form may **not** be used to authorize release of HIV-related information or psychotherapy notes that are recorded and kept separately by a mental health professional documenting the contents of a conversation during a counseling session. After completing this form, please mail it to:

HIP Health Plan of New York  
Outbound Call Unit  
Customer Service, 2nd Floor  
55 Water Street, New York, NY 10041-8190

It may also be faxed to 1-646-447-3069.

■ ■ ■ PLEASE PRINT ■ ■ ■

All numbered sections must be completed for this authorization to be considered valid under HIPAA privacy rules.

## Section 1) MEMBER INFORMATION

Member's Name: \_\_\_\_\_

Member ID #: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Home Telephone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## Section 2) INFORMATION TO BE DISCLOSED

I authorize HIP to disclose my protected health information as follows:

- All claims, billing information, benefit or coverage information.
- All behavioral health information (excluding psychotherapy notes).
- All information noted above, including genetic information.
- Specific information only; please list:  
\_\_\_\_\_

## Section 3) RECIPIENT OF INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

## Section 4) REASON FOR DISCLOSURE

- At my request.  
- or -
- For the following purposes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Section 5) TERM OF AUTHORIZATION

- Authorization will remain in effect until the \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_\_\_.  
- or -
- Authorization will remain in effect until I revoke it in writing, or for a period of six (6) years, or as prescribed by law.

## CONDITIONS OF AUTHORIZATION

I understand that:

- I may refuse to sign this authorization.
- I will receive a signed copy of the authorization.
- The information released to a third party pursuant to the authorization may no longer be covered by state and federal privacy laws.
- I have the right to revoke the authorization at any time, and that the revocation must be in writing and sent to: HIP Health Plan of New York, Compliance Department, 13th Floor, 55 Water Street, New York, NY 10041-8190. It may also be faxed to 1-646-447-3217.
- The revocation will be effective immediately upon HIP's receipt of my written notice, except that the revocation will not affect any action taken by HIP in reliance on the authorization prior to receiving my written notice of revocation.
- The authorization will be maintained by HIP for a period of six (6) years or as prescribed by law.
- HIP will not condition my enrollment or eligibility for health insurance benefits on my provision of the authorization, unless it requested the authorization before my enrollment solely for eligibility or enrollment determinations relating to me.
- HIP may not condition payment of a claim for specified health insurance benefits on my provision of the authorization.

## Section 6) SIGNATURE REQUIRED

I have read and understood the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby knowingly and voluntarily authorize the use and disclosure of my health information in the manner described above.

Signature of Member \_\_\_\_\_ Date \_\_\_\_\_

**The signature of the member or their personal representative is necessary. A parent must sign for a minor dependent child. Documentation must be attached if the individual signing has power of attorney or is the legal guardian.**

Signature of Personal Representative \_\_\_\_\_ Date \_\_\_\_\_

## Section 7) DESCRIPTION OF AUTHORITY

- Parent  Legal Guardian\*\*  Power of Attorney\*\*

\*HIP includes the Health Insurance Plan of Greater New York and HIP Insurance Company of New York.

\*\*Documentation is required to demonstrate legal guardianship or power of attorney.