BAPTIST HEALTH PLAN®

Authorization for the Use and Disclosure of Protected Health Information (PHI)

Section A: Authorization: I authorize Baptist Health Plan (BHP) to use and/or disclose my PHI as described in Sections B and C. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

NAME: _____PHONE NUMBER: _____ MEMBER ID:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

Section B: Description of PHI to be disclosed. Describe in detail the PHI to be used and disclosed (you can state "any and all" or provide specific information such as the providers, dates of treatment or type of service that you would like to disclose): _____

This authorization applies to the information described below (mark all those that apply):

☐Records covering the period of time for: _____

☐Information regarding the following condition or injury [please describe] _____on or about this date_____

☐ Other [please be specific and include dates] _____

Please check if your authorization will include the disclosure of the following types of PHI:

☐ Substance abuse (including alcoholism) ☐ AIDS, AIDS-related complex, or HIV

☐ Mental health services (excluding psychotherapy notes)

Section C: Authorized recipient of the PHI – State on the line below who you are authorizing to receive PHI. *If PHI is disclosed under your authorization to persons or organizations that are not subject to federal or state privacy laws, it may be re-disclosed and no longer protected.*

NAME: _____ PURPOSE: _____

☐ I authorize the following person or entity to disclose my PHI to BHP

Section D: Expiration and Revocation

This authorization will expire in **two (2) years**. If you wish for this authorization to expire sooner, please enter the date of the expiration: [please list a **specific date**]:_____

I understand that this authorization is voluntary and that I may refuse to sign. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or the ability to obtain treatment, **except that**,

- if this authorization is for BHP to determine eligibility before enrollment, and the requested use or disclosure is not for psychotherapy notes, then BHP reserves the right to deny enrollment or eligibility for benefits if I refuse to sign, **or**
- if this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information**,** then BHP reserves the right to deny that health care if I refuse to sign.

- I understand that I have a right to request and receive a copy of BHP's Notice of Privacy Practices.
- I understand that I have the right to revoke this authorization at any time by sending written notification to Baptist Health Plan, Attention: Privacy Officer, 651 Perimeter Drive, Suite 300, Lexington, KY 40517.
- I understand that a revocation is not effective to the extent that the persons I have authorized to use and/or disclose my individually identified health information have acted in reliance upon this authorization.
- I further understand that if this authorization was obtained as a condition of obtaining insurance coverage, other law provides BHP with the right to contest a claim under the policy, or the policy itself.
- I understand the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

Please keep a copy of this authorization for your records.

Section E: Signature _____ *Date*_____

Section F: Personal Representative – If you are not the member, please sign and date section F of this form. Check the box that describes your relationship to the member. If you are not the parent, please attach proof of your relationship to the member (e.g., power of attorney, personal representative documentation, etc.).

Printed name and signature of personal representative: _____

☐ Parent of minor child ☐ Legal guardian ☐ Power of Attorney ☐ Executor ☐ Other

_____

Description of Personal Representative (Please provide representative documentation)

Discrimination is against the law.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1.800.787.2680** (TTY: 1.844.708.1389).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1.800.787.2680** (TTY：1.844.708.1389).

BAPTIST HEALTH PLAN®

INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Fill out the form completely. The authorization is not valid unless it is filled out completely.
This form cannot be used as a joint authorization with another member, therefore, each member must submit a separate form.

Please type or print the information.

Section A: Authorization. Please include the following information about the member whose PHI is being disclosed:

1) Member's first and last name
2) Member's telephone number, including area code
3) Include the member's ID number as it appears on the member's ID card
4) Member's full street address, including city, state, and ZIP code

Section B: Description of PHI to be disclosed

1) List the information to be used and disclosed (for example you can put "any and all" or list the specific claims or dates covered by the authorization).
2) Check the appropriate box if you wish to disclose the following types of PHI:
    a. Substance abuse (including alcoholism)
    b. AIDS, ARC, HIV
    c. PHI related to mental health services.

Section C: Authorized recipient of the protected health information

1) If you want us to disclose PHI, list the person or entity to whom the PHI will be disclosed. Include first and last name when you want to authorize a specific individual to receive your PHI.
2) Please describe the purpose for the disclosure. You may simply state "at my request" if appropriate.
3) If you are authorizing another person or entity (such as a hospital or doctor) to release PHI to us, please check the box and list the person or entity who you are authorizing to provide PHI to us.

Section D: Expiration and Revocation

1) The authorization will expire in **two (2) years**. If you wish for this authorization to expire sooner, please enter the date of expiration (day, month and year).
2) Members can revoke authorizations at any time. Revocations must be submitted in writing to BHP at the address listed below.

Section E: Signature - Members must sign and date the authorization unless the form is completed by their personal representative (see below).

Section F: Personal Representative

1) If a personal representative is signing the authorization form on behalf of a member, the representative must sign his or her name and date in the signature line and specify his or her relationship to the member by checking the appropriate box below the signature. Please attach representative documentation.
2) The personal representative must print his or her name, relationship to the member and authority to sign. If the personal representative is someone other than the parent of a minor child, written proof is required.

BEFORE RETURNING THIS FORM YOU SHOULD KEEP A COPY FOR YOUR RECORDS

Mailing Instructions	Faxing Instructions
Baptist Health Plan Attn: HIPAA Privacy Officer 651 Perimeter Drive, Suite 300 Lexington, KY 40517	**To Customer Service use: 859.335.4110** **To Appeals use: 859.335.3720**

Members who need additional assistance completing this form should call a customer service representative at 859.269.4475 or 800.787.2680.

Discrimination is against the law.
Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1.800.787.2680** (TTY: 1.844.708.1389).
Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1.800.787.2680** (TTY：1.844.708.1389).