Authorization for Release of Protected Health Information (PHI)

My health record is private and is known under the law as "Protected Health Information (PHI)." I understand that this authorization is voluntary. The information released may not be released by the recipient without my authorization except for the purpose of treatment, payment, healthcare operations, and as required by law. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal or state privacy laws.

I, or my legal representative, understand that by voluntarily signing this form I am identifying, authorizing, and granting permission to all HealthTeam Advantage (HTA) to share my PHI with the people or company listed below.

The purpose of this disclosure is:

_____

_____

1. Member information (person whose information will be released):

Name			
First	**Middle**	**Last**	**Date of Birth**
Address			
Street	**City**	**State**	**Zip Code**

2. HealthTeam Advantage can share my PHI with the following people or companies:

Person or Company Name		**Phone Number**	
Street	**City**	**State**	**Zip Code**
Person or Company Name		**Phone Number**	
Street	**City**	**State**	**Zip Code**

3. HealthTeam Advantage can share ONLY my records chosen below.

I only want to share the PHI I have checked below. This authorization cannot be used to share psychotherapy notes.

☐ Information about your eligibility ☐ Plan enrollment ☐ Claims ☐ Premium payments

☐ Grievance and appeals ☐ Pharmacy records

☐ Other Specific Information _____

Sensitive Information: (this information may include diagnosis and/or treatment information)

☐ Substance use disorder (alcohol/drug) ☐ HIV/AIDS ☐ Sexually transmitted diseases

☐ Behavioral health/mental health (but NOT psychotherapy notes).

☐ Other (please explain) _____

_____

4. This form will be valid for two (2) years, unless a shorter timeframe is listed below.

My authorization is valid from		
MM/DD/YYYY	to	MM/DD/YYYY

MEMBER'S RIGHTS AND SIGNATURE

1. I hereby authorize the use or disclosure of my individually identifiable health information as described above. This includes information pertinent to mental health, drug/alcohol abuse, and HIV/AIDS diagnosis.
2. I understand that HealthTeam Advantage cannot make me sign this authorization as a condition to receive treatment, payment, enrollment, or eligibility for benefits except where this authorization is sought for HTA's eligibility or enrollment determinations or for its underwriting or risk rating determinations and the authorization is not for a use or disclosure of psychotherapy notes.
3. I understand that this authorization is voluntary. The information released may not be released by the recipient without my authorization except for the purpose of treatment, payment, healthcare operations, and as required by law. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal or state privacy regulations.
4. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to HealthTeam Advantage. I understand the revocation will not apply to information that has already been released in response to this authorization. Send correspondence to: HealthTeam Advantage, Customer Service, P.O. Box 662, Southborough, MA 01772.
5. I understand that, if I request my records to be e-mailed or faxed, this is not considered secure and my health information could be viewed by someone other than me.
6. I understand there may be a charge associated with the Release of Information should I, or my legal representative, request.
7. I have a right to receive a copy of this authorization. A copy is as valid as the original.

Member Signature **Date/Time**

Signature of: ☐ **Authorized Representative** *(attach copy of legal documents)* **Date/Time**