EmblemHealth®

Authorization to Use or Disclose Protected Health Information

By completing this Authorization Form, I voluntarily authorize EmblemHealth to use or share my protected health information with the person(s) and/or organization(s) I have listed on this form.

INSTRUCTIONS

The instructions below explain the information that EmblemHealth needs from you. If you have questions or need help, call our Customer Service team at the number on the back of your member ID card or visit **emblemhealth.com/contact** for more information on how to contact us. We recommend that you fully read the form before you complete it.

Fill out the form completely.

1. **MEMBER INFORMATION:** Fill in the member ID number, name, address, phone number, and birth date here.
2. **RECIPIENT INFORMATION:** Who can we share this information with?
3. **PURPOSE OF THE AUTHORIZATION:** Tell us why you are asking us to share your information and add any other information that we may need to know in order to share your information.
4. **INFORMATION TO BE DISCLOSED:** Tell us the type of information you are authorizing us to share. If you want to share only certain information, write it in the space provided.

   We will not share sensitive information like behavioral health and HIV/AIDS information unless you specifically tell us to. Write your initials where indicated to release any of this information.
5. **TERM OF AUTHORIZATION:** Tell us how long we should continue to release this information and when to revoke (cancel) your authorization.

   - If you check the first box, you can fill in the day, month, and year that this authorization should end.
   - If you check the second box, you can describe when this authorization should end.

   Important: If you do not give us an end date or event on this form, your authorization will stay in effect for 24 months from the date you sign it.
6. **CONDITIONS OF AUTHORIZATION:** Read this section all the way through. It has important information about what can happen to your information after we release it.
7. **SIGNATURE REQUIRED:** We can't release your information unless you or your personal representative signs the form. If a personal representative is submitting the request, he or she must sign this form. A personal representative is a person who, under law, has the authority to act on your or your dependent's behalf to make health care-related decisions.

   The request must include written proof (like proof of legal guardianship or power of attorney). We need to see this to make sure that this person has the right to act on your or your dependent's behalf.

   Note that some forms, like a durable power of attorney form, may only give a personal representative a limited right. The right(s) given to the representative must include the ability to request and receive protected health information. This may be done by giving the individual the right to make health care decisions.

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All required sections of this form must be completed for it to be valid. See the Instructions for more information on how to complete this form. Once you have filled out the form, send it to your plan at the address provided at the end of this form.

1. MEMBER INFORMATION

Member ID number:	Member name:
Mailing address:	
Phone number (optional):	Date of birth:

2. RECIPIENT INFORMATION

This is the person(s) or organization(s) EmblemHealth can share my information with:

Name:	
Address:	
Phone number (optional):	Relationship:

3. PURPOSE OF THE AUTHORIZATION — The disclosure is limited to the specific purpose provided.

☐ At my request. **OR** ☐ For the following purpose(s): _____

4. INFORMATION TO BE DISCLOSED

I authorize EmblemHealth to disclose my protected health information described below:

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

OR

☐ Specific information only. Please list: _____

Sensitive information:

Initial below to allow information related to any of the following to be shared with the recipient provided on this form. This type of information needs to be authorized specifically.

☐ All substance use disorders (alcohol/drug)

OR

☐ Only the following substance use disorder (alcohol/drug):

_____

_____

☐ Mental health (except psychotherapy notes)

☐ Genetic information (including genetic test results)

☐ HIV/AIDS

☐ Sexually transmitted disease(s)

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5. TERM OF AUTHORIZATION

☐ Authorization will end on: (month/day/year) _____ / _____ / _____

OR

☐ Authorization will end upon the following event:

_____

Important: If you do not specify an end date or event, this authorization will remain in effect for 24 months from the date this Authorization Form was signed, or until you "revoke" or cancel it in writing, whichever is earlier.

Revoking or Canceling the Authorization:

I understand I that have the right to revoke (cancel) this authorization at any time. The revocation (cancelation) must be in writing, signed and dated, and sent to the address at the end of this form.

Any revocation (cancelation) will be effective as soon as EmblemHealth receives my written notice. I understand that EmblemHealth may have released information based on my earlier authorization, before they received the revocation (cancelation).

6. CONDITIONS OF AUTHORIZATION

I understand that:

- The information that is shared by this authorization might be shared again by the person(s) or organization(s) who receive it and may no longer be protected by law.
- I may refuse to sign this authorization. If that happens, EmblemHealth cannot require me to sign it to enroll or stay enrolled in my plan. I will still be eligible for health benefits and my treatment will not be affected by whether or not I sign this Authorization Form. EmblemHealth may not require me to sign it in order to pay for or receive specified health benefits.
- I understand that this form does not allow EmblemHealth to provide psychotherapy notes. Psychotherapy notes are those notes that are taken by a mental health professional during my appointment. If those notes are needed, I will fill out a separate form: Authorization to Use or Disclose Psychotherapy Notes, which can be requested by calling the Customer Service team at the number on the back of my member ID card.
- If I authorize EmblemHealth to release HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, federal law bans the recipient from disclosing that information or using it without my authorization, unless permitted to do so under federal or state law.
- If I am discriminated against because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at **888-392-3644**. This agency is responsible for protecting my rights.
- I understand that the phone numbers I provided on this form may be used by EmblemHealth or any of its contracted parties to contact me about my account, my health benefit plan or related programs, or services provided to me.

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7. PERSONAL REPRESENTATIVE

☐ Check here if you are signing as an authorized personal representative and provide your information below. Please attach appropriate documentation (e.g., legal guardian, power of attorney, court order, etc.). For more information, please see the Instructions.

Printed Name: _____

Relationship to the Member: _____

8. SIGNATURE REQUIRED

The member or an authorized personal representative **must sign** this form. A parent must sign for a dependent child under 18 years old.

I have read and understood the terms of this authorization. I have also had a chance to ask questions about how my health information will be used and shared.

By signing this authorization, I confirm that the information on this form is complete and accurate, and follows my wishes.

I authorize the use and disclosure of my health information in the manner described in this form.

Member signature: _____ Date: _____ / _____ / _____

Personal representative signature: _____ Date: _____ / _____ / _____

☐ Parent ☐ Legal Guardian* ☐ Power of Attorney* ☐ Other*

*You must include documentation that proves you have legal authority to act for the member.

Once you have completed this form, please mail to:

EmblemHealth
Customer Service Department
P.O. Box 1701
New York, NY 10023-1701