

## **Authorization Form Instruction Sheet**

1. The attached Authorization Form must be completed if you are requesting GHI to release your protected health information (for example, claims and medical management information) to a third party. Once you give us authorization to release your health information, we cannot guarantee that the third party will not disclose the information. Note: Authorizations are not required when the information being released is for payment, treatment or operations.
2. The member or personal representative must completely fill out and sign the attached Authorization Form. Note: If the request is signed by any person but the member, you must provide legal documentation (such as authorization form, proof of legal guardianship, power of attorney) that permits you to act on the member's behalf.

### **Who is a personal representative?**

- For an adult or an emancipated minor, a personal representative is an individual with legal authority to make health care decisions on behalf of the individual. This can be through a power of attorney, a health care proxy, a court order, or as a legal guardian.
- For an unemancipated minor, a personal representative is a parent, a guardian or someone legally acting as a parent or guardian with authority to make health care decisions on behalf of the minor.
- For a deceased individual, a personal representative is an individual with legal authority to act on behalf of the decedent or the estate. It may be the executor of the estate or the next of kin. Note that in New York State, a durable power of attorney expires upon death.

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

GHI reserves the right to request any supporting documentation.

3. Please send the completed, signed and dated form to:

GHI - Your Department

P.O. Box ???

New York, New York 10001-XXXX



**PURPOSE OF AUTHORIZATION: (check one)**

Release this information for the following purpose:

\_\_\_\_\_  
\_\_\_\_\_

OR

At my request

**EXPIRATION/ REVOCATION**

This authorization will expire on (check one):

Date \_\_\_\_\_

OR

When the following has occurred:

\_\_\_\_\_  
\_\_\_\_\_

You may revoke this authorization at any time by writing to GHI, **YOUR DEPARTMENT ADDRESS, CITY, STATE, ZIP**. Cancelling your authorization will take effect when GHI receives your letter. GHI may still use and disclose the information for the purposes listed above if we have already acted in response to your authorization.

I (name) \_\_\_\_\_ have read and understand the contents of this authorization. I understand that by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described on this form.

Note: Personal representatives must include legal documentation recognized under applicable law which provides you legal authority to act on behalf of the individual member. Please see instruction sheet for more detail, if applicable.

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Print Your Name

\_\_\_\_\_  
Date

Send completed and signed form to:

**GHI  
XXXX  
New York, NY 10001-XXXX**