

HIP HEALTH PLANS* 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.

Member's Name: _____

HIP ID #: _____

Home Address: _____

Home Telephone: _____

Date of Birth: _____

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

INFORMATION TO BE DISCLOSED

Include genetic information.

RECIPIENT OF INFORMATION

Name: _____

Address: _____

REASON FOR DISCLOSURE

At my request.

- or -

For the following purposes: _____

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, but for no longer than 24 months from the initial date of authorization.

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 Plans' HIPAA Privacy Officer: Valerie Reardon, SVP, Corporate Compliance and Internal Audit, 7 West 34th Street, New York, New York 10001.
- ✓ The revocation will be effective immediately upon HIP Health Plans' receipt of my written notice, except that the revocation will not affect any action taken by HIP Health Plans in reliance on the authorization prior to receipt of my written notice of revocation.
- ✓ The authorization will be maintained by HIP Health Plans for a period of six (6) years or as prescribed by law.
- ✓ HIP Health Plans 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 Health Plans may not condition payment of a claim for specified health insurance benefits on my provision of the authorization.

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 HIP Health Plans to use or disclose my health information in the manner described above.

Signature of Member

Date

If member is a minor or otherwise unable to sign this authorization, the following is required:

Signature of Personal Representative

Date

DESCRIPTION OF AUTHORITY

Parent Legal Guardian** Power of Attorney**

*HIP Health Plans is comprised of 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.