Amalgamated Medical Care Management
Quality Clinical Advice & Care

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

| **1. Individual for Whom Health Information is Being Requested** | | | |
|---|---|---|---|
| First and Last Name: | Date of Birth: | Social Security #: | Member ID#: |
| Street Address: | | | Phone # ( ) |

| **2. Person(s) or Category of Person to Receive this Information** | | |
|---|---|---|
| Full Name of Person or Business Entity : | Relationship to Individual: | |
| Address: | Phone # ( ) | Fax # ( ) |

**3. Specific Information to Be Disclosed:** *Check the appropriate boxes*

☐ Only records for the following dates: ____/_____/_____ to ____/_____/_____

☐ My entire record including hospital and medical claims, treatment history, prescriptions, office notes, billing records, insurance records, and records sent by other health care providers.

☐ Other : _____

_____

You must initial next to each applicable category of records below that you wish to be included in the disclosure.

_____ Alcohol/ Drug Treatment

_____ HIV-Related Information

_____ Sexual Health, (STD/ STI)

_____ Mental Health Records

****Psychotherapy notes will not be disclosed*

**4. Purpose of the Disclosure:** *Check one*

☐ At the request of the Individual ☐ Other: _____

**5. Length of Authorization:** *Check as applicable*

☐ This Authorization will expire on the following date: _____/_____/ _____

☐ This Authorization will expire upon the following event: _____

**If you do not select an expiration date or event, the authorization will expire after two (2) years.

** You can revoke your authorization at any time prior to the date or event that you selected by notifying us in writing.

**6. Statement of Understanding:**

**By writing my signature below, I attest that I understand and agree to the following statements**:

- I am the Individual who is the subject of the disclosure request, or an authorized personal representative thereof.
- I sign this authorization voluntarily and understand that I have the right to refuse to sign. My treatment, payment, enrollment in a health plan, or eligibility for benefits cannot be conditioned upon my signing this form.
- I can revoke this authorization at any time by notifying Amalgamated Medical Care Management in writing of my request. Such revocation have no effect on disclosures that were made or actions taken prior to my written notification.
- I understand that information disclosed pursuant to this authorization might be further disclosed by the recipient identified in Section #2, and that Amalgamated Medical Care Management has no control over such further disclosures.
- All items on this form have been completed, and my questions about this form have been answered.
- I am entitled to receive a copy of this form and to request an accounting of disclosures of my PHI.

**Signature: _____ Print Name: _____ Date: _____**

**If signed by an authorized representative, indicate the relationship to the individual: _____

## INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FORM

| ABOUT THIS FORM |
|---|
| The Health Insurance Portability and Accountability Act ("HIPAA") requires that a written authorization be obtained before sharing your protected health information ("PHI") with a third party, including your spouse or family member, your employer, union representative, or your attorney. PHI is health information about you, your receipt of or payment for health care treatment or services, or your health coverage in the past, present, or future that directly identifies you, or could be used to identify you. Except as permitted by law, your PHI cannot be shared with persons not specifically identified in your authorization. If you want several people to have access, you must complete a separate form for each.<br><br>This form must be completed by you, the Individual who is the subject of the PHI, or by a personal representative authorized to act on your behalf. You can designate anyone you wish to serve your personal representative, by providing Alicare Medical Management a written statement indicating such designation. A spouse or family member does not have an automatic right to access your information unless you state in writing that such person is your personal representative or complete an authorization form naming that person. A person who has an executed health care power of attorney or health care proxy can be treated as a personal representative. A minor child's parent or legal guardian is generally an authorized representative, but state law can prevent access to certain information concerning sexual health and substance use, or when the child is emancipated, or abuse, neglect or domestic violence are suspected. The executor or administrator of a deceased person's estate, or a person authorized by a court or state law to act on behalf of the deceased can be treated as a personal representative. |

| INSTRUCTIONS | |
|---|---|
| **Section #1** | Provide the full name (first and last) and street address of the individual whose health information is being requested. Include date of birth, social security number, and member ID # (if known). |
| **Section #2** | Provide the complete name of the person or business entity that will receive the health information of the person named in Section # 1. Include a complete mailing address, in addition to a phone number, and a fax number if you wish for the information to be sent by fax. (Records will generally be mailed) |
| **Section #3** | Check <u>one</u> of the three boxes indicating what information should be disclosed to the person named in Section #2. You can choose to have only records created between certain dates or your entire record disclosed. If neither option is applicable, you select "other" and describe the records that you want to disclosed (i.e. dermatology records for date of service 3/3/19).<br><br>Records concerning alcohol or drug treatment, sexual health (STD/STI), HIV-Related Information and Mental Health Records are deemed "highly sensitive" PHI and have special protections under the law. If these records are to be released, you must initial next to each type of information to be included. |
| **Section #4** | Indicate the purpose for which the records are being disclosed. You can check "at the request of the individual" or indicate a specific purpose. |
| **Section #5** | Check the appropriate box to indicate the date or specific event upon which the authorization shall end. If you do not specify a date or event, the authorization will automatically end after two (2) years. You can later choose to end the authorization before the date or event specified by notifying us in writing. |
| **Section #6** | Read through the "Statement of Understanding" which lists certain rights that you have. Sign your and print your name at the bottom of the form. The form will not be valid unless dated. If someone other than the Individual named in Section 1 is completing the form, be sure to indicate your relationship to the individual. We may call to request additional information from an authorized representative.<br><br>**If you have any questions while completing the form, do not hesitate to call us at (800) 863-8688.** |

<u>Submit the Completed Form to</u>: **Amalgamated Medical Care Management**
**8C Industrial Way**
**Salem, New Hampshire 03079**
**Fax: (603) 894-7067**