univera HEALTHCARE

Important Facts Regarding Your Authorization to Share Protected Health Information

- In order to comply with Federal HIPAA regulations, health plans must obtain a member's permission to share his/her protected health information with any other person. There are limited exceptions to this.

- As permitted by law, we will continue to communicate to providers of care involved in your treatment: (1) our payment activities in connection with your claims, (2) your enrollment in our health plan and (3) your eligibility for benefits.

- Until a child reaches age 18, parents may access most of their child's health information without first obtaining the child's permission. However, regardless of the child's age, parents do not have access to diagnosis or treatment information for sexually transmitted diseases, abortion, HIV/AIDs and drug or alcohol abuse unless the child specifically authorizes the release of such information.

- This form is used to authorize us to share your protected health information. Each person you identify will have the same access to your information. If you would like each person to access *different* information or to have access to your information for a *different* period of time, you'll need to complete separate forms for each individual or time period.

- We will NOT disclose information relating to genetic testing, substance use disorder, mental health, abortion, and sexually transmitted disease information unless you initial the corresponding condition in Part D. If you would like to authorize us to release information regarding HIV/AIDS, New York State requires that a different form be completed. To obtain a copy of this form, please contact our office at the telephone number listed on your identification card, or access the form at the following website: https://www.health.ny.gov/diseases/aids/providers/forms/informedconsent.htm

- If you need additional forms, you may copy this form, contact our office at the telephone number listed on your identification card or visit our Web site at https://www.univerahealthcare.com and search for "Manage Your Privacy".

- Please ensure you have fully completed the form so that we may honor your request.

RETAIN A COPY FOR YOUR RECORDS

AUTHORIZATION TO UNIVERA HEALTHCARE ("HEALTH PLAN") TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

☐ **Check here only if you are authorizing access to psychotherapy notes.** If checked, this form **cannot be used for any other purpose.** You must complete a separate form for authorizing access to any other information.
If this box is checked, skip Part D.

PLEASE PRINT

PART A: Member/Individual Who Is the Subject of the Information To Be Disclosed			
Last Name	First Name	MI	Date of Birth
Current Address	City	State	Zip Code
Member Identification Number (located on member ID card)			

PART B: Health Plan Can Share My Information With the Following Person(s)	
Name of Person/Organization	Address
Name of Person/Organization	Address

PART C: Reason for Member/Individual (Part A) Authorizing Disclosure

☐ At my request ☐ Other: _____

PART D: Health Plan Can Share the Following Information
*(select D-1 **or** D-2 and if applicable, D-3)*
NOTE: Skip this section if psychotherapy was checked at the top of this form

D-1. ☐ I would like you to disclose any information requested by the person or entity named in Part B. This includes information in Part D-3 (below) only if I placed my initials next to the condition. If my initials do not appear in D-3, information related to those conditions will not be disclosed.

- OR –

D-2. I would like to limit the disclosure of information to a specific type of information, provider, condition or date(s). If this area is blank I do not wish to limit the disclosure of my information.

☐ Enrollment *(e.g. eligibility, address, dependents, birth date)*
☐ Benefit *(e.g. benefit coverage, usage, limits)*
☐ Claim *(e.g. status, provider, dates, payment, diagnosis)*
☐ Clinical records *(e.g. doctor/facility, case management)*
☐ Other limitation:_____
☐ Date Range _____ to _____

CONTINUED ON THE NEXT PAGE

- AND, IF APPLICABLE -

D-3. Unless specifically indicated below, information will not be disclosed related to the following conditions. If I have placed my initials next to one or more of these conditions, the Health Plan is authorized to disclose information related to those conditions.

____ Genetic testing	____ Substance use disorder	____ Mental health *(excluding psychotherapy notes)*
____ Sexually transmitted diseases	____ Abortion	

Note: A separate form must be completed in order to authorize release of information related to HIV/AIDS. The NYS approved form can be found at http://www.health.ny.gov/diseases/aids/providers/forms/informedconsent.htm

PART E: Acknowledgement (Please read and sign)

I understand that:

- I can revoke this authorization at any time by writing to the Health Plan at the address listed below except this revocation would not affect any action taken by the Health Plan in reliance on this authorization before my written revocation is received.
- Information disclosed as a result of this authorization may be re-disclosed by the recipient. Federal and state privacy laws may no longer protect my PHI.
- Health Plan will not condition my enrollment in a health plan, eligibility for benefits or payment of claims on my giving this authorization.
- This authorization will remain in effect until the Health Plan receives my written cancellation notice, **or**, until the date I specify here: _____

IMPORTANT: I have read and understand the terms of this authorization. I hereby authorize the use and disclosure of my protected health information in the manner described in this form.

Signature: _____ Date: _____

If this request is from a personal representative on behalf of the member, complete the following:

Personal Representative's Name: _____

Personal Representative Signature _____ Date: _____

Description of Authority: ☐ Parent ☐ Legal Guardian* ☐ Power of Attorney*

☐ Other* _____

**You must provide documentation supporting your legal authority to act on behalf of the member*

RETURN TO:
Univera Healthcare
P.O. Box 211256
Eagan, MN 55121
or Fax: 315-671-7079

Please keep a copy for your records