Authorization for Use and Disclosure of Protected Health Information

Please Print:
Member (Patient) Name _____ Date of Birth _____

Member (Patient) Address _____

_____ Member I.D. #: _____

I authorize Physicians Health Plan (PHP) to use and disclose my (or patient's) protected health information to the following person(s):

(specify-please print) _____,

Please check the appropriate box or boxes below. You may write in any additions or limitations. Authorization is not valid if this section is not filled out.

Copies or contents of the following records may be used/disclosed as requested:

☐ All healthcare information including any mental health, drug/alcohol abuse, or communicable disease treatment records that may be maintained by PHP.

☐ Limit disclosure to all healthcare information, **EXCLUDING** any mental health, drug/alcohol abuse, or communicable disease treatment records that may be maintained by PHP.

☐ Limit disclosure to Benefit / Coverage information.

☐ Other (specify) _____

_____

☐ Limit above disclosure to healthcare services provided between the following dates: _____/_____/_____ to _____/_____/_____

Purpose of the disclosure: C*heck the appropriate box or boxes, or fill in blanks that apply. Authorization is not valid if this section is not filled out.*

☐ Personal use or assistance ☐ Assistance with a grievance/appeal ☐ Legal action* (please specify) ☐ Other (please specify)

*Please describe legal action or other purpose _____

This authorization expires on _____ (If no date is specified, this authorization expires 180 days after the signature date.)

Important Information About Your Rights

I understand that:

- I am not required to sign this authorization to receive my benefits except as allowed by law, such as when a disclosure is necessary for PHP to determine payment of a claim.
- I may request a copy of this signed authorization.
- I may revoke this authorization at any time prior to the expiration date by sending a written request to PHP; however, the revocation will not have any effect on any actions PHP took prior to receiving the revocation.
- The health information indicated above may no longer be protected by federal privacy regulations if disclosed to a party that is not a health plan or healthcare provider.
- If I choose to designate a representative to assist me, the representative will have access to my protected health information.

Signature of Member (Patient) _____ Date _____

If Patient is under the age of 18 years, or is otherwise unable to sign, a parent or other legally authorized individual should sign below.

Signature for Patient _____ Date _____

Please print name clearly _____

Relationship to Patient: (please check appropriate box) ☐ Parent ☐ Spouse ☐ Legal Guardian* ☐ Power of Attorney*

☐ Other authorized representative* (please specify relationship) _____

☐ Authorized as Next of Kin (use if patient is deceased or incapacitated, and no other authorized representative has been designated). Please specify relationship _____

* Please supply applicable documentation of legal guardianship, power of attorney, or other legal authorization to represent Patient.

PLEASE NOTE: EACH SECTION OF THIS FORM MUST BE COMPLETED IN ORDER TO BE VALID.

If you need assistance to complete this form, please contact Customer Service (260) 432-6690, extension 11; (800) 982-6257, extension 11; or (260) 459-2600 for the hearing impaired. Please return completed forms to PHP Customer Service at 8101 W. Jefferson Blvd., Fort Wayne, IN 46804, or by email to custsvc@phpni.com.