AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Complete this form to authorize GlobalHealth to disclose your protected health information (PHI) to another person or organization. For assistance, please call the Customer Care phone number on your Member ID card. Only a completed form will be accepted to process your request.

MEMBER FULL NAME:

MEMBER ID NUMBER: DATE OF BIRTH:

SOCIAL SECURITY NUMBER: PHONE NUMBER: (   )

ADDRESS:

CITY: STATE: ZIP:

I HEREBY AUTHORIZE GLOBALHEALTH TO RELEASE MY PROTECTED HEALTH INFORMATION (PHI) TO THE PERSON OR ORGANIZATION IDENTIFIED BELOW FOR THE PURPOSE(S) I HAVE INDICATED. I UNDERSTAND THAT SUCH DISCLOSED INFORMATION MAY BE REDISCLOSED BY THE RECEIVING PERSON OR ORGANIZATION AND WOULD NO LONGER PROTECTED BY FEDERAL PRIVACY LAWS.

RECEIVING PERSON/ORGANIZATION NAME:

RELATIONSHIP TO MEMBER:

PURPOSE FOR DISCLOSURE:

PHONE NUMBER: (   ) FAX NUMBER: (   )

ADDRESS: EMAIL (*if electronic format requested*):

CITY: STATE: ZIP:

INFORMATION TO BE DISCLOSED: Check the following boxes for all information you would like to be disclosed. If the information to be disclosed is not listed, please check the "Other" box, and describe what information is to be disclosed in the space provided. *A separate authorization form must be completed to authorize the disclosure of any psychotherapy notes.*

- ☐ CLAIMS INFORMATION (related to payment of your claims for service you received, including billed amounts, allowable amounts, claim payment or denial reasons, etc.)
- ☐ HEALTH PLAN BENEFIT INFORMATION (as found in your member materials, including copayments, coinsurance, eligibility, and other benefit information)
- ☐ PREMIUM INFORMATION (related to premium amounts, bank draft changes, etc.)
- ☐ SERVICE DETERMINATION INFORMATION (related to pre-service, concurrent, or post-service authorizations)
- ☐ OTHER: ____

YOUR INITIALS ARE REQUIRED TO RELEASE THE FOLLOWING INFORMATION:

_________Mental Health Records (excluding psychotherapy notes)

________Genetic Information, Test Results and Treatment

________Drug, Alcohol, or Substance Abuse Records

________HIV/AIDS Test Results and Treatment

EFFECTIVE TIME PERIOD: Check one box below to indicate when this authorization form will expire:

☐ One year after the date this form is signed

☐ Upon my/member's date of death

☐ Upon minor member reaching the age of majority

☐ Other: ______________________

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving GlobalHealth written notice stating my intent to revoke this authorization. I understand that prior actions taken in reliance on this authorization by GlobalHealth or anyone that had permission to access my health information will not be affected.

RIGHT TO AMEND: I understand that I can change the details of my permission at any time by giving GlobalHealth written notice describing my requested change(s) to this authorization. I understand that prior actions taken in reliance on this authorization by GlobalHealth or anyone that had permission to access my health information will not be affected.

PROHIBITED ACTIONS: I understand that a healthcare provider or health plan may not condition treatment, payment, enrollment, or eligibility in a health plan or eligibility for healthcare benefits on my signing this authorization except under state or federal law.

RIGHT TO RECEIVE A COPY: I understand that I have a right to receive a copy of this authorization.

VOLUNTARY AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as I have described or indicated on this form. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or applicable state privacy laws.

____ ____

SIGNATURE OF MEMBER OR LEGAL REPRESENTATIVE DATE

LEGAL REPRESENTATIVE'S NAME: ____

ADDRESS: ____________________ PHONE NUMBER: (   ) ____________________

CITY: ____________________ STATE: ____________ ZIP: ____________

LEGAL REPRESENTATIVE'S AUTHORITY/RELATIONSHIP (additional documentation may be requested):

☐ Parent of Minor

☐ Guardian or Conservator

☐ Attorney-in-Fact under Power of Attorney

☐ Healthcare Proxy under an Advance Directive or Living Will

☐ Other: _________________________________

CONSENT OF MINOR: A minor individual's signature is required for the release of certain types of information, including the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

____ ____

SIGNATURE OF MINOR DATE

Please submit the completed and signed form to: GlobalHealth
P.O. Box 1747
Oklahoma City, OK 73101
Fax: (405) 280-2960