# 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. You may call the Customer Care phone number on your Member ID card for assistance. 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 BE PROTECTED BY FEDERAL PRIVACY LAWS.**

RECIPIENT FULL NAME _____

RELATIONSHIP TO MEMBER _____

PURPOSE FOR DISCLOSURE _____

PHONE NUMBER (___) _____ FAX NUMBER (___) _____

ADDRESS _____ EMAIL _____

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 indicate 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, including billed amounts, allowable amounts, claim payment or denial reasons, etc.)
- ☐ APPEALS & GRIEVANCES INFORMATION (related to complaints or objections to claim or authorization denials)
- ☐ HEALTH PLAN BENEFIT INFORMATION (as found in your member materials, including copayments, coinsurance, eligibility and other benefit information)
- ☐ 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)

_____Drug, Alcohol, or Substance Use Records

_____Genetic Information, Test Results and Treatment

_____ HIV/AIDS Test Results and Treatment

**EFFECTIVE TIME PERIOD:** Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following date or event:

- ☐ My/Member's Date of Death
- ☐ Minor Member Reaching the Age of Majority
- ☐ Date (MM/DD/YYYY): _____
- ☐ 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 specifically 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 GlobalHealth does not condition treatment, payment, enrollment, or eligibility for healthcare benefits on my signing this authorization.

**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 voluntarily 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:**

Attn: Customer Care
GlobalHealth
Oklahoma City, OK 73102
Fax: (405) 280-2960

**REVOCATION OF AUTHORIZATION**

I, _____, HEREBY REVOKE THIS AUTHORIZATION TO USE OR DISCLOSE PHI.

_____ _____

SIGNATURE DATE