



## Authorization for Use and Disclosure of Private Health Information

**NOTE:** Your enrollment in a health plan, eligibility for benefits, processing and payment of claims, or treatment is not conditioned on giving this authorization.

**I. Identification of person authorizing release** (The following is needed for verification. Please complete all applicable items.)

Name of Member/Participant: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Member ID card number: \_\_\_\_\_

Group or Account Number on ID card: \_\_\_\_\_

Subscriber's name (if different from Participant): \_\_\_\_\_

Subscriber's relationship to Participant: \_\_\_\_\_

Subscriber's Employer Name: \_\_\_\_\_

Subscriber's Social Security Number (if different from Member): \_\_\_\_\_

*If you have dual coverage, please complete the following information as well:*

Subscriber's Employer Name: \_\_\_\_\_

Number on Participant ID card: \_\_\_\_\_

Group or Account Number on ID card: \_\_\_\_\_

**II. Description of Private Health Information to be Released**

Insert what information you are authorizing to be released. Describe in detail the kind of information (e.g. claims information, premium information, medical records, etc.) you want released, and if applicable the date(s) of the information (e.g. claims for the last 6 months, premium payment record for January).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In addition, if you agree that the following types of information may be released, please indicate so by checking the appropriate boxes:

- Psychotherapy Notes\*     Mental Health Records     Genetic Testing Records
- HIV/AIDS Records     Maternity Records     Sexual/physical/mental abuse
- Sexually transmitted or other communicable diseases     Alcohol & substance abuse records

\* If this authorization is for psychotherapy notes, this authorization cannot be used for any other type of protected health information. If you want to authorize the use or disclosure of other protected health information as well, and additional form must be submitted.

**Who can release and receive the information:** Insert the person/company who is allowed to release the information and the person/company who is allowed to receive the information. The following person/company is allowed to release the information as requested:

\_\_\_\_\_

The information can be provided to (include name and address):

\_\_\_\_\_

### III. Purpose of this release information

- At the request of the covered individual
- If not requested by the individual, state the purpose of the release of information: \_\_\_\_\_

\_\_\_\_\_

### IV. Expiration Date

If not previously revoked, this authorization will terminate on the earliest of the following dates:

- (1) the date the individual's coverage ends; or
- (2) one year from the signature date below; or
- (3) upon the following date, event or condition: \_\_\_\_\_

### V. Signature:

A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original. I understand that if this information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my information described above may be re-disclosed by the recipient and no longer protected by federal privacy regulations. This authorization is subject to revocation at any time upon written notice to the person/company specified above except to the extent that the person/company has already taken action on the disclosure provisions contained in this document.

\_\_\_\_\_ Date: \_\_\_\_\_  
(Signature of adult member/parent on behalf of minor, as applicable, and date)

\_\_\_\_\_ Date: \_\_\_\_\_  
(Signature of Legal Representative, if applicable, and date)

If a legal representative signs on behalf of the individual, the following must be completed:

**FOR POWER OF ATTORNEY:**

I \_\_\_\_\_ do hereby swear that I have been appointed legal power of attorney over \_\_\_\_\_.

I, \_\_\_\_\_, do hereby grant permission on behalf of medical provider(s), to release records pertaining to his/her medical care, including but not limited to medical, billing, and insurance records, to \_\_\_\_\_  
\_\_\_\_\_

I also allow the health plan and providers to discuss with the Office of the Healthcare Advocate his/her case as necessary to resolve any outstanding claim for coverage and/or pre-certification of coverage for any medical service rendered for his/her benefit.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Power of Attorney signature)

On Behalf of: \_\_\_\_\_  
(Patients Name)

**Please complete this form and mail to:**  
Office of the Healthcare Advocate  
Attention: Director, Consumer Relations  
P.O. Box 1543  
Hartford, CT 06144-1543

**Fax: (860) 297-3992**