Authorization for Use and Disclosure of Private/Protected Health Information
Instruction Sheet

TOP OF FORM: OHA STAFF MEMBER SELECTION

1. In the center box, click the drop down box to select the staff member who sent you the form **or** write-in the staff member's name in the box if you are completing the form by hand.
2. In the center box, click on the e-mail address of the staff member who sent you the form **or** write-in the staff member's e-mail address in the box if you are completing the form by hand.

SECTION I: CONSUMER INFORMATION

1. Complete the name, address, phone number(s), e-mail address, gender, and date of birth for the **"Subscriber"**, who is the person who has the policy (e.g., parent for a child or spouse on his spouse's plan).
2. Complete the name, address, phone number(s), e-mail address, gender, and date of birth for the **"Member or Patient"**, who is the person named in this case/complaint.

PLEASE NOTE: If this case is related to a child with mental health or substance use issues and the child is 16 or older, the child is required to sign a separate release authorizing release of mental health or substance use records.

SECTION I-A: DEMOGRAPHIC INFORMATION

1. Per federal grants received by OHA to perform our services, we are required to collect information on ethnicity, race, marital status, employment, income and veteran status of the **"Member or Patient"** we are serving. We use this information to report on the demographic information of our consumers only. This information is not readily shared.

SECTION II: INSURANCE INFORMATION

1. Insurance Cards: Please provide a copy of your card (front and back) to OHA.
2. Complete this section with the use of your Insurance ID or Connect (Medicaid) Card to fill in the name and address of the insurance company, Subscriber ID and group number, employer's name, employee's name, and the relationship to the **"Member or Patient"** (e.g. self, mother/father, spouse, etc.). If you have more than one type of insurance, please complete that information; use a separate sheet of paper if necessary. *We collect your employer name to help us determine what kind of healthcare coverage you have.*

SECTION III: PRIVATE HEALTH INFORMATION FOR RELEASE

1. Please describe the health information that you authorize for release and receipt. It is important to capture as much information as possible that is **related** to the case. Please include all dates of service, services received, diagnosis, etc.
2. Please be sure to include any additional parties who you authorize to release or receive your health diagnosis and/or insurance information. Please note that we cannot get information from or share information with them without the companies' names on this form.
3. Please list the hospitals, doctors and/or providers who have the necessary medical information and whom we may contact. Include the address and phone numbers for each facility/provider. If necessary, please use a separate sheet of paper for additional providers. Please **initial** all hospitals/providers given.

Please note that the State of Connecticut regulates fully insured plans. These plans include individual insurance plans and certain group plans, including small group plans.

SECTION IV: PURPOSE OF RELEASE

1. Purpose: Please check the appropriate option and complete those areas requiring additional information.
2. Expiration: Please check the appropriate option and complete those areas requiring additional information. Many individuals choose the last option and write/type in "at the completion of the case"

SECTION V: SIGNATURE

1. Please remember to sign and date the form and include a power of attorney if you are acting on behalf of someone who is not your child or who is incapacitated.

APPOINTMENT OF REPRESENTATIVE: If you have a **Medicare** case, please fill out the appointment of representative form. Otherwise, you can disregard.

If you've completed the form online, please print it and either scan and return it by (1) e-mail to the appropriate staff, (2) fax it to the staff's attention at (860) 297-3992 or (3) mail it to the address shown on the top of page 1.

Office of the Healthcare Advocate
STATE OF CONNECTICUT

Please complete this form and return via

MAIL: Office of the Healthcare Advocate
Attn: Select an OHA Staff Member
P.O. Box 1543
Hartford, CT 06144-1543

OR FAX: (860) 297-3992

OR E-MAIL: Select an E-Mail Address

PLEASE NOTE:
This Authorization is available in Microsoft Word and Adobe Fillable PDF format; either format can be saved for future use.

OHA must receive the form with a signature (not typed).

Authorization for Use and Disclosure of Private/Protected Health Information

NOTE: Your enrollment in a health plan, eligibility for benefits, processing, and payment of claims, or treatment is not a condition of this authorization!

I. Identification of Person Authorizing Release *(The following is needed for verification. Please complete all applicable items.)*

Name of **Subscriber**:_____ Date of Birth: _____

Address: _____ Gender: ☐ Female ☐ Male

City:_____ State:_____ Zip Code (+4):_____

Telephone Number(s): (H):_____ (W):_____

(C):_____ (Fax):_____

E-mail Address:*_____

I am the Person Authorized to Release Medical Information for: ☐ SELF ***(skip to I.A)*** ☐ CHILD/ FAMILY MEMBER ☐ OTHER

I would like primary communication via e-mail ☐ YES ☐ NO

Name of **Member/Patient**:_____ Date of Birth: _____

Address: _____ Gender: ☐ Female ☐ Male

City:_____ State:_____ Zip Code (+4):_____

Telephone Number(s): (H):_____ (W):_____

(C):_____ (Fax):_____

E-mail Address:*_____

Section I.A – Requested Demographic Information Specific for the Individual receiving OHA Assistance**

Member/Patient ETHNICITY: ☐ Hispanic / Latino ☐ Not Hispanic / Latino

Member/Patient RACE : ☐ Asian-American ☐ Black / African-American ☐ Native American
☐ Pacific Islander ☐ White / Caucasian ☐ Unknown/Other:_____

Member/Patient is: ☐ Single ☐ Married ☐ Separated ☐ Divorced
☐ Civil Union ☐ Domestic Partner ☐ Widowed ☐ Child

Member/Patient is: ☐ Full-Time Employed (☐ one job / ☐ two jobs+ / ☐ self) ☐ Part-Time Employed ☐ Student/Minor
☐ Retired ☐ Unemployed (☐ looking for work / ☐ not looking for work) ☐ Disabled / Not Working ☐ Unknown

Member/Patient Income Source: ☐ Wages ☐ Pension/Retirement ☐ SSI ☐ SSDI
☐ Child Support ☐ Unemployment Benefits ☐ Other/Unknown ☐ None

Member / Patient heard about OHA: ☐ Insurance Denial ☐ Provider/Hospital ☐ Media/Advertisement
☐ State Agency/Legislator ☐ Attorney/Broker ☐ Outreach Event ☐ Referral/Info-Line (211)
☐ Federal Agency/Legislator ☐ Social Media/Website ☐ Other:_____

Member / Patient is a Veteran? ☐ YES ☐ NO

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* OHA uses e-mail to communicate with clients. Please be advised that our e-mail communications are made through a secured server, which requires you to complete a one-time set-up to access the secured e-mail(s).

** Please complete the federally Requested Demographic Information section; this information is used solely for aggregate reporting purposes and will not be shared with any person or entity.

II. Insurance Information [*Please provide front and back copy of your card(s). | Please use separate sheet for additional insurance carriers.*]

Primary Insurance Company Name:_____

Primary Insurance Company Phone:_____

Subscriber or Patient Member ID Card Number: _____

Group or Account Number on ID card:_____

Subscriber's Employer Name: _____

Subscriber's Employee Name (if different from Member's):_____

Subscriber's Relationship to Member:_____

***** ***** ***** ***** *****

Secondary Insurance Company Name:_____

Secondary Insurance Company Phone:_____

Patient Member ID Card Number: _____

Group or Account Number on ID card:_____

Subscriber's Employer Name: _____

Subscriber's Employee Name (if different from Member's):_____

Subscriber's Relationship to Member:_____

III. Description of Private Health Information to be Released: Describe briefly **in the box** below what information you are authorizing to be released. Describe in detail the kind of information (e.g. claims information, premium information, medical records including test results, etc.) you want released, and if applicable, the date(s) of service/ information (e.g. claims for the last 6 months, premium payment record for January, etc.). **Use a separate sheet if necessary.**

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

☐ Progress 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 you want to authorize the use or disclosure of other protected health information as well, an additional form must be submitted. Please see the last page of this authorization, which describes in more detail further disclosure of HIV/AIDS records and Alcohol & Substance Abuse records.**

The Release and Receipt of Health Information: Please inset the person(s) / company (-ies) allowed to release and receive health information. The following are authorized to information, as indicated:

- The Office of the Healthcare Advocate ☒ Release Information ☒ Receive Information
- All Insurers and Providers listed in Sections II and III ☒ Release Information ☒ Receive Information
- _____ ☐ Release Information ☐ Receive Information
- _____ ☐ Release Information ☐ Receive Information
- _____ ☐ Release Information ☐ Receive Information
- _____ ☐ Release Information ☐ Receive Information

The Office of the Healthcare Advocate is authorized to contact and obtain information from the Healthcare Provider(s) and/or Facility (-ies) listed below. Please affix your initials next to each provider; use additional pages if necessary, with each provider initialed by you.

Patient Initials	Provider / Hospital Name	Complete Address	Phone Number

IV. Purpose of this Release of Information | Expiration Date

The purpose of this Release of Information is: *(please check one)*

☐ At the request of the covered individual;

☐ If not requested by the individual, please state the purpose for the release of information in the box below:

If not previously revoked, this authorization **will expire** on the earliest of the following dates: *(please check one)*

☐ the date the individual's coverage ends; or

☐ one year from the signature date below; or

☐ 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. A copy of this authorization will also serve as the original if multiple disclosures are required. 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 redisclosed 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(s)/company(-ies) specified above except to the extent that the person(s)/company(-ies) have already taken action on the disclosure provisions contained in this document. This authorization indicates your approval to release the protected health information obtained in connection with this authorization to the State of Connecticut Insurance Department for regulatory purposes.

_____ Date: _____

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

_____ Date: _____

(Signature of Legal Representative, if applicable, and date)

NOTE: If you are signing this authorization as the legal representative of an individual, we **must have a copy of the form(s)** verifying your right to authorize the disclosure of protected health information and to view such information.

In addition to the protections from disclosure listed throughout this document / authorization form, any information released to the Office of the Healthcare Advocate (OHA) by authorized persons is subject to the following notices:

Psychiatric Information:

In the event that information released to OHA constitutes confidential psychiatric information protected under Connecticut law:

This information has been disclosed to OHA from records whose confidentiality is protected by state law. State law prohibits OHA from making further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law.

Drug and Alcohol Abuse Information:

In the event that information released to OHA is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:

This information has been disclosed to OHA from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit OHA from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

HIV-Related Information:

In the event that information released to OHA constitutes confidential HIV-related information protected under Connecticut law:

This information has been disclosed to OHA from records whose confidentiality is protected by state law. State law prohibits OHA from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose.

APPOINTMENT OF REPRESENTATIVE: To be completed only if your case involves Medicare.

Name of Beneficiary	Medicare Number

SECTION I: APPOINTMENT OF REPRESENTATIVE (To be completed by the Medicare Beneficiary)

I appoint this individual: _____ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to illicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

Signature of Beneficiary		Date
Street Address		Phone Number (with Area Code)
City	State	Zip

SECTION II: ACCEPTANCE OF APPOINTMENT (To be completed by the Representative)

I, _____ hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the beneficiary's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a/an: *(Please indicate the professional status / relationship to the Medicare Beneficiary, e.g., Staff, Attorney, Relative, etc.)*
☐ OHA Employee ☐ Attorney ☐ Relative: _____ ☐ Other:_____

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip

SECTION III: WAIVER OF FEE FOR REPRSENTATION

Instructions: This form should be filled out if the representative waives a fee for such representation.

(**Note:** Providers or Suppliers may not charge a fee for representation and thus, all providers or suppliers that furnished items or services as issue **must** complete this section.)

I, _____, waive my right to charge and collect a fee for representing _____before the Secretary of the Department of Health and Human Services.

OHA STAFF SIGNATURE_____ DATE_____

Duplicated from the Department of Health and Human Services Centers for Medicare & Medicaid Services | Form Approved OMB No. 0938-0950
Form CMS-1696 (07/05) | EF (07/05)