Authorization to Release Information

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows AmeriHealth Administrators (your health benefits administrator) to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to AmeriHealth Administrators **(contact the Privacy Official at 215-793-6910 for further instructions).** Revoking this authorization will not affect any action taken prior to receipt of your written request.

Member Information: (individual whose information will be released)

Name: (First, Middle, Last, Title)		**Date of Birth:** (Month/Day/Year)
Address: (including zip code)		**Telephone Number:** (including area code)
Group Number:	**Social Security Number:**	**ID Number:**

Health Benefits Administrator: (organization that will release your information)

I authorize AmeriHealth Administrators to release my protected health information as described below.

Recipient: (person or organization that will receive your information)

Person's Name or Organization: RECORDS DEPOSITION SERVICE, INC.	**Telephone Number:** (including area code) (248) 357-3330
Address: (including zip code) PO BOX 5054, SOUTHFIELD, MI 48086-5054	**Fax Number:** (if available) (248) 357-3337

Description of the Information to be Released: (what type of information will be released)

Check only one box:

❑ **Psychotherapy notes** – Federal law requires an authorization to use or release psychotherapy notes.
If you check this box, you may not check another box below.

❑ **All information related to the provision of and payment for my health care benefits or services.***

❑ **Specific information described below:***

____

Examples: The claim related to my service on (date); Appeal information related to my claim on (date)

Purpose of Release: FOR DISCOVERY BEFORE TRAIL

____

Examples: At my request; To resolve my appeal; To assist with my health benefits services

***NOTE:** Certain State laws require that you give specific permission to release the information below even if you checked a box above. Indicate your permission for AmeriHealth Administrators to release any of the following information by initialing all that apply.

Genetic Information	___________ (Initials)	**HIV/AIDS**	___________ (Initials)
Substance/Alcohol Abuse	___________ (Initials)	**Mental/Behavioral Health**	___________ (Initials)

Expiration: (when this authorization will end)

This authorization will expire on ____/____/____(mm/dd/yyyy) **OR (but not both)** on the occurrence of the following event:

____

Examples: Until I revoke this authorization; Resolution of a specific issue

Approval: (You OR your personal representative must sign and date this form in order for it to be complete.)

I understand that this authorization to release information is voluntary and is not a condition of enrollment in my health plan, eligibility for benefits, or payment of claims. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws.

Member Signature: By signing below, I authorize the use of my protected health information.	**Personal Representative Information:** A personal representative is a person who has the legal authority to act on behalf of an individual. A copy of a Power of Attorney or other court-related legal document must be on file at the health plan.
____________ (Signature of Member)	____________ Printed Name of Personal Representative) ____________ (Date) ( ) ____________ (Telephone Number)
____________ (Date)	____________ (Signature of Personal Representative) ____________ (Description of representative's authority)

Please keep a copy of this form and the instructions for your records

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Instructions - Authorization to Release Information

This form is used for you or your Personal Representative to authorize AmeriHealth Administrators, your health plan's claims administrator, to release your Protected Health Information to another person or organization at your request. "Protected Health Information," means individually identifiable health information. It is information about you, including your name, address, and medical information, and may relate to your past, present, or future physical or mental health or condition. AmeriHealth Administrators maintains information that may include eligibility, benefits, claims, or payment information.

Member Information: (individual whose information will be released)

Print your complete name, address, date-of-birth, and telephone number. Provide your group and Social Security number.
Important: Provide the member ID Number located on the front of your health plan identification card.

Recipient: (person or organization that will receive your information)

The recipient is a person or organization to whom you want AmeriHealth Administrators to send your Protected Health Information. You must provide all of the contact information in order for the information to be released.

- Identify the person, family member, or organization to receive your information.
- Provide the contact information for the person, family member, or organization

Description of the Information to be Released: (what type of information will be released)

You must indicate or describe the information to be released. **Check one box that best describes your request**. There are three choices. The first choice is **Psychotherapy Notes**. The second choice is **All Information**. The third choice is **Specific Information** that you must describe on the line provided.

If this authorization is to release Psychotherapy Notes, AmeriHealth Administrators cannot release any other information unless you complete another Authorization to Release Information form.

Psychotherapy Notes are notes recorded by a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session. These notes are separated from the rest of the individual's medical record. **An authorization to release Psychotherapy Notes cannot be combined with an authorization to release any other type of information.**

All Information. If you check this box AmeriHealth Administrators may release all information related to the provision of a payment for your health care benefits or services. If someone is directly involved in coordinating your health care or benefits, you may want them to have access to all of your information.

Specific Information. By checking this box, you indicate that you want only specific information to be released. Describe the specific information on the line provided.

Purpose of Release. You must provide a brief description of the reason you want this information released. The statement, "At my request" is sufficient.

IMPORTANT: State law requires that you give specific permission to release certain health information. Your initials are required on each line in order for AmeriHealth Administrators to release HIV/AIDS, Substance/Alcohol Abuse, Genetic, or Mental/Behavioral Health information.

Expiration: (when this authorization will end)

Print either an expiration date OR event, but not both. If an expiration event is used, the event must relate to the purpose for which the release of information is being authorized.

Approval: (You OR your personal representative must sign and date this form in order for it to be complete.)

Member Signature.	Personal Representative Information.
If you are the individual whose information will be released, you must sign and date in this section.	If you are the personal representative, the Member's signature is not required. However, you must provide the requested information, sign and date this form. A copy of the legal authority establishing your personal representative status, such as a Power of Attorney or other court initiated document, must be on file with AmeriHealth Administrators.

Authorization to Release Information

The enclosed Authorization Form is required in order to allow AmeriHealth Administrators, your health plan's claims administrator, to release your Protected Health Information to another person or organization. Please review and complete the form. A number of important points are highlighted here, for more detailed instructions please refer to the instructions on the back of the Authorization Form. If you have any questions please contact the Privacy Official at 215-793-6910.

Each section of the form must be completed; missing information will result in delays in processing the authorization.

- ❑ Include your Social Security/Member Identification Number
- ❑ List in the "Recipient" section the name of the person or organization to whom you are authorizing AmeriHealth Administrators to release information. Be sure to include the recipient's contact information such as telephone number, fax number, or address.
- ❑ Review the "Description of the Information to be Released" section before completing.
  - ✓ You should only check **one** of the three boxes listed.
  - ✓ If you select the "Psychotherapy Notes" box, you cannot check any other box
  - ✓ If someone routinely assists you with your health care, for example your husband, wife, son or daughter, you may want to give that person access to all of your information. To do this, check the second box in this section and initial any/all applicable areas in the *Notes section.
  - ✓ Check the "Specific Information" box if an individual is assisting you in resolving a particular issue such as an appeal, and initial any/all applicable areas in the *Notes section.
  - ✓ A "Purpose of Release" must also be noted.
- ❑ An "Expiration" must be listed. You can allow the Authorization to remain in effect until you revoke it in writing. You may also indicate that the Authorization will expire on a specific date, or at the conclusion of an event, such as an appeal.
- ❑ You <u>or</u> your Personal Representative must sign the Authorization Form. If your Personal Representative signs the Authorization, a copy of the legal documents which authorize him/her to act as your Personal Representative must be submitted with the Authorization Form.
- ❑ Return the completed Authorization Form to the following address:

RECORDS DEPOSITION SERVICE, INC.
PO BOX 5054
SOUTHFIELD, MI 48086-5054

P: 248-357-3330
F: 248-357-3337

Please keep a copy of this form and the instructions for your records