Instructions to complete the Highmark Health Options Authorization to Use and Disclose Protected Health Information Form

Section A: Member Information

1. Write the first and last name of the member whose information is being disclosed.
2. Write the member's identification number.
3. Write the member's address.
4. Write the member's date of birth.
5. Write the member's telephone number.

Section B: Information to Use and Disclose

1. Check what information you would like used or shared. Check all that apply.
2. Please note that some records require special permission to release. Check all that apply.
3. Check who is authorized to disclose the information. In most cases is will be **Highmark Health Options**.
4. Write who you are authorizing to receive the information. At minimum, include name and address.
5. Check the reason the information will be used or disclosed. In most cases the information will be used or disclosed at **the member's request**.

Section C: Revocation of Authorization

1. Please understand that you may revoke this authorization at any time by giving written notice of your revocation to Highmark Health Options. Revocation of this authorization will not affect any action Highmark Health Options took in reliance on this authorization before we received your written notice. Your revocation may be sent to:

   Privacy Department
   Highmark Health Options
   PO Box 890419
   Camp Hill, PA 17089

2. Unless otherwise revoked, this authorization will expire at the termination of your coverage with Health Options. If you would like it to expire at a different date, please write that date in the lines provided at the end of Section C.

Section D: Signature

1. This Authorization must be signed and dated by the member whose information is to be released.
2. If the member is unable to sign this Authorization, a personal representative with legal authority on file with Highmark Health Options may sign and date the form.

Section E: Personal Representative – Optional

A Personal Representative is a person entitled to act under applicable law to act on behalf of a Highmark Health Options member. This section should only be completed if another individual has legal capacity to sign on behalf of the member. You may end this designation at any time in writing.

1. Write the full name of the personal representative the member is choosing to elect.
2. Write the personal representative's telephone number.
3. Write the personal representative's address.
4. Write the personal representative's relationship to member.
5. Write the type of legal document that grants your personal representative authority to make decisions on your behalf. Examples include: Power of Attorney, Custodial Order, Guardianship, Executor of Estate, etc.
6. Attach a copy of the legal document.

Parents and Legal Guardians

If you are the parent or legal guardian of a minor child, you do not need to complete this authorization if our records show you are the head of household or we have other information in our records to show you are the child's parent or legal guardian. If you would like a copy of the minor child's records, please complete an Access Request. Only complete this form if you want us to send the information to someone other than yourself.

Authorization to Use and Disclose Protected Health Information

Section A: Member Information (Please Print)	
Member Name:	Member ID:
Address:	
Date of Birth:	Telephone:

Section B: **Information to use and disclose** (check all that apply)	
☐ Enrollment information ☐ Claims information ☐ Payment information ☐ Managed Care information (Care Coordination,Case Management) ☐ Explanation of Benefits ☐ Clinical Records ☐ All records ☐ Other (please specify):	Some records require special permission to release. Please release records pertaining to: ☐ Pregnancy Family Planning ☐ Mental/Behavioral Health ☐ Developmental Disabilities ☐ HIV/AIDS Testing or Treatment ☐ Sexually Transmitted Disease ☐ Alcohol and/or substance use
Who Is Authorized to use or disclose the Information: ☐ Highmark Health Options	
Who will receive the information: (Please specify) Name: Address:	**Reason the Information Will Be Used or Disclosed**: ☐ At the member's request ☐ Coordinating care for dependent or spouse Insurance eligibility/benefits ☐ Claims resolution ☐ Further medical care ☐ Other (please specify):

Section C: Revocation of Authorization

I understand that I may revoke this authorization at any time by giving written notice of my revocation to Highmark Health Options. I understand that revocation of this authorization will not affect any action Highmark Health Options took in reliance on this authorization before it received my written notice of revocation. I also understand that without my written authorization, Highmark Health Options may not use or disclose my health information for any reason except those described in Highmark Health Options' Notice of Privacy Practices. Unless otherwise revoked, this authorization will expire:

☐ The termination of my coverage ☐ Other date: _____/_____/_____

Section D: **Signature**

I understand that authorizing the disclosure of health information is voluntary. I do not need to sign this authorization to receive health care services except if the only purpose for providing me with a service is to obtain health information to disclose to someone else, then I must authorize that disclosure in order to receive the service.

PLEASE FILL OUT THE REVERSE SIDE OF THIS FORM

I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned about my authorization of this disclosure, except if this authorization is sought for the purpose of determining my eligibility for benefits or enrollment, then I must authorize Highmark Health Options to obtain the necessary information.

I understand that I have the right to revoke this authorization at any time to the address below.
I understand that Highmark Health Options may still disclose information if they have already taken action based on this authorization.

Privacy Department
Highmark Health Options
PO Box 890419
Camp Hill, PA 17089

I understand that under federal law I do not have to authorize Highmark Health Options to receive private notes from counseling sessions that are kept by a mental health professional, as a condition of payment, enrollment in a health plan, or eligibility for benefits.

I understand that information disclosed under this authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law.

Signature: ______________________________ Date: ______________

If this authorization is signed by someone who is not the member listed at the top of this form, attach any documents (i.e. general power of attorney) that verify the signer's authority to act for the member.

If you are a Personal Representative filling out this form for a Highmark Health Options member, please write that relationship below and the legal reason that gives you this right (i.e. Power of Attorney, guardian, etc.). If you have not done so, you will be required to fill out Section E of this form, below.

If you are not the member, print your name:	Relationship to member:
Legal form on file:	Telephone number:
Address:	

Section E: Personal Representative (Optional): You have the option to select a Personal Representative to act on your behalf. If you do not want to select a Personal Representative, or already have one, leave this section blank.

Name:	**Telephone:**
Address: (Please include Street, City, State, and ZIP)	**Relationship to member:**

Type of Documentation: A copy of a Power of Attorney or other court-initiated document must be ATTACHED to this form in order for it to be processed. Attach supporting documentation: Power of Attorney, Custodial Order, Guardianship, Executor of Estate, etc.

You are entitled to a copy of this authorization after you sign it.

HIGHMARK
HEALTH OPTIONS

Discrimination Is Against the Law

Highmark Health Options complies with applicable Federal civil rights laws and regulations and does not discriminate on the basis of race, color, national origin, age, disability, health status, sex, sexual orientation or gender identity. Highmark Health Options does not exclude people or treat them differently because of race, color, national origin, age, disability, health status, sex, sexual orientation or gender identity.

You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Help in Your Language

Highmark Health Options provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, Braille, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, se encuentran disponibles servicios de asistencia con el idioma sin costo alguno para usted. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711).

Si w pale kreyòl ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou do kat idantifikasyon w lan (TTY: 711).

注意：如果您讲中文，可以免费为您提供语言协助服务。拨打您的 卡背面的号码（听障人士专用号码：(TTY: 711）。

注：英語を話す場合は、無料の言語支援サービスを利用できます。 あなたのIDカードの裏面（： 711 TTY）の番号を呼び出します。

ધ્યાન આપશો: જો તમે ગુજરાતી બોલતા હોવ તો, તમારા માટે ભાષા સહાયતા સેવાઓ મફતમાં ઉપલબ્ધ છે. તમારા આઇડી કાડડની પાછળ આપેલા નાંબર પર ફોન કરો (TTY: 711).

ATTENTION: Si vous parlez français, des services d’assistance linguistique vous sont offerts gratuitement. Veuillez appeler le numéro qui se trouve au verso de votre carte d’identification (TTY : 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 카드 뒷면의 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: Se parla italiano, per Lei sono disponibili servizi di assistenza linguistica gratuiti. Chiami il numero presente sul retro della Sua carta di identificazione (TTY: 711).

LƯU Ý: Nếu quý vị nói Tiếng Việt, luôn có các dịch vụ hỗ trợ ngôn ngữ được cung cấp miễn phí cho quý vị. Vui lòng gọi số điện thoại trên mặt sau của thẻ nhận dạng của quý vị (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen kostenlose Unterstützung in Ihrer Sprache zur Verfügung. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TYY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, may maaari kang kuning mga libreng serbisyo ng tulong sa wika. Tawagan ang numero sa likod ng iyong card (TTY: 711).

कृपया ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएं आपके लिए निशुल्क उपलब्ध है। अपने पहचान कार्ड के पीछे दिए गए नंबर पर कॉल करें (TTY: 711)।

توجہ دیں: اگر آپ اردو بولتے/بولتی ہیں تو، آپ کے لیے زبان کی اعانت کی خدمات مفت دستیاب ہیں۔ اپنے آئی ڈی کارڈ کے پیچھے درج نمبروں پر ہمیں کال کریں (ٹی ٹی وائی: 711)۔

تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل على الرقم المدوّن على ظهر بطاقة هويتك (الهاتف النصي: 711).

గమనిక: మీరు తెలుగు మాట్లాడే వారైతే, భాషా సహాయక సేవలు, ఖర్చు లేకుండా, మీరు లభిస్తున్నాయి. మీ ఐడి కార్డుకు (TTY: 711) వెనుక వైపు ఉన్న నంబర్ కి ఫోన్ చేయండి.

Highmark Health Options is an independent licensee of the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield Plans.