



INSTRUCTION SHEET FOR CALOPTIMA HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

SECTION A: MEMBER INFORMATION

This section applies to the member who is asking for the release of his or her information to another person or organization. Please complete all items of information in this section.

SECTION B: INFORMATION THAT CAN BE RELEASED

This section tells us what information you would like us to release. Be specific regarding the types of documents you are authorizing for release. For example, if you are authorizing an individual to obtain PHI related to a recent medical event, specify the date of the medical event, the types of documents you are requesting (e.g. billing records, pre-authorization records, or pharmacy records) and state any types of records you would like to exclude.

SECTION C: PURPOSE OF THIS AUTHORIZATION

Select the reason(s) you've asked for the release of your information. If you have a specific reason, please fill in under "**Other**" and indicate the reason. For example, if you only want the person(s) or organization(s) you are authorizing to receive your protected health information for a pending claims appeal, you would enter "*To appeal a claim determination*" or something similar in that block.

SECTION D: PERSON OR ORGANIZATION AUTHORIZED TO RECEIVE THIS INFORMATION

Please enter the name(s) of the person(s) or organization(s) that you are authorizing to access your PHI. For example, if you are authorizing your spouse, adult child, or any other individual to obtain your PHI, enter his/her name in these spaces. If you are authorizing an organization (such as a broker, law firm, insurance agency, etc.) to obtain your PHI, enter the specific name of the organization in these spaces. **Examples include: "Dr. John Smith" or "Mary Doe (spouse)."** Indicate how the person(s) or organization(s) is related to you (for example, spouse, adult child, etc.) and provide their phone number.

SECTION F: EXPIRATION DATE OF AUTHORIZATION

Check the first box if you want the authorization to end on a certain date. Enter in the date of expiration. Check the second box if you wish for the authorization to expire on a certain event, for example, *“one year from my signature date.”*

SECTION G: SIGNATURE

If you are the member, sign your name and enter the date you signed the form. **Please be advised that in order to process your request, a copy of a valid government issued photo identification (ID) document with your signature must be included with your request form.**

If you are the member's personal representative, sign your name, enter the date you signed the form and indicate your representative relationship. **Please be advised that in order to process your request, a copy of a valid government issued photo identification (ID) document with your signature must be included with your request form.** You **must** also provide us with a copy of the legal documentation indicating you are the authorized personal representative of the member.

• Examples of legal documents:

- **Power of Attorney for Health Care** — this document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
- **Legal Guardianship** — this is when the court appoints someone to care for another person.
- **Conservatorship of the Person** — this happens when the court appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
- **Executor of Estate** — this type of document would be used when the person who is being represented has died.

Please keep a copy of the form for your records.