Authorization for Disclosure of Health Information

Please print clearly in blue or black ink.

This form is used to release your protected health information (PHI) as required by federal and state privacy laws. PHI is information about you that may identify you and relates to your past, present, or future physical or mental health or condition and related health services. This includes all information about your health evaluations, diagnoses, and treatments, and/or prescription records. Your authorization allows Prestige Health Choice (your insurance carrier) to release your PHI to a person or organization you choose. You can revoke this authorization at any time by submitting a request in writing to Prestige Health Choice. Revoking this authorization will not affect any action taken prior to receipt of your written request.

Here is what you need to know:

This form is used to release your PHI. By signing this form, you allow us to share or use your health information. This information may identify you to others. Your PHI includes all information about your health, treatments, and medicines. PHI can refer to your physical or mental health. By signing this form, you allow Prestige Health Choice to release your PHI to a person or organization you choose. Even if you sign the form, you can still change your mind about sharing information. Just let us know. You can tell us by mailing a letter to our office. Once we receive the letter, we will stop using your information. But we cannot take back any information we shared before you revoke the authorization. Contact Member Services at **1-855-355-9800** for more information.

Section A. Member information

Tell us the individual whose information will be released.

Name (first, middle, last):	
Member ID number:	Date of birth (month/day/year):
Address (including ZIP code):	
Phone number (including area code):	

Section B. Health plan information

Tell us the organization that will release your information.

I authorize Prestige Health Choice to release my PHI.

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Leading the Way to Quality Care

Section C. Recipient information

Tell us the person or organization that will receive your information (attach additional pages as necessary).

Name of person or organization:	
Phone number (including area code):	Fax number (if available):
Address (including ZIP code):	

Name of person or organization:	
Phone number (including area code):	Fax number (if available):
Address (including ZIP code):	

Section D. Description of the information to be released

Tell us what type of information we can share. Check only one box.

☐ Psychotherapy notes. These are notes from a mental health professional. Federal law requires a separate authorization to use or release psychotherapy notes. (If you check this box, you may not check another box below. You can fill out another form to release other information.)

☐ All information related to the provision of and payment for my health care benefits or services. This excludes any period of time during which a Confidential Communication Address was in effect.

☐ Specific information as described in the box below:

Examples:

- The claim related to my service on [date].
- Appeal information related to my claim on [date].

Note: Some laws might require that you give specific permission to release the information below even if you checked a box above. Please check the boxes below that relate to information it is OK to share. By checking these boxes and initialing, you give permission for Prestige Health Choice to release that information.

☐ Genetic information	Initials:	☐ Sexually transmitted disease	Initials:
☐ HIV/AIDS	Initials:	☐ Abortion and family planning	Initials:
☐ Substance or alcohol use	Initials:	☐ Mental or behavioral health	Initials:

Let us know why you are releasing this information:

Section E. Expiration

Tell us when this authorization will end:*

Check only one box.

This authorization will expire:

☐ When I revoke this authorization.*

☐ When my coverage with Prestige Health Choice ends.

☐ Upon the following date, event or condition:_____*

* The party identified in Section B must be notified in writing of the event or condition to cancel or revoke this authorization. This consent is subject to revocation at any time except to the extent that the program that is to make the disclosure has already taken action in reliance on it.

Section F. Approval

You or your personal representative must sign and date this form for it to be complete.

I understand that this authorization to release information is voluntary and is not a condition of enrollment in Prestige Health Choice, 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 health information privacy laws, they may further release the PHI and health information privacy laws may no longer protect it.

Here is what you need to know:

It is your choice to sign this form. Your benefits will not change if you do not sign the form. You will still be a Prestige Health Choice member. But if you do not sign this form, we cannot share your information or give your PHI to the people you want us to give it to. It is important to know that the person or organization that receives your PHI may be able to release it further.

By signing below, I authorize the release of my PHI as described above.

Member name (print):
Member signature:
Date:

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 legal documentation must be on file at Prestige Health Choice or submitted with this form.

Printed name of personal representative:	
Description of representative's authority:	
Signature of personal representative:	Date:
Phone number (including area code):	

Return the completed authorization form to:
Prestige Health Choice
P.O. Box 7181
London, KY 40742

You can also fax it to us at **1-855-236-9281**.

This information is available for free in other languages. Please contact our customer service number at **1-855-355-9800** or TTY/TDD **1-855-358-5856**, 24 hours a day, 7 days a week.

Esta información está disponible en otros idiomas de forma gratuita. Comuníquese con nuestro número de servicio al cliente al **1-855-355-9800** o TTY/TDD **1-855-358-5856**, las 24 horas del día, los 7 días de la semana.

Enfòmasyon sa a disponib gratis nan lòt lang. Tanpri rele sèvis kliyan nou annan nimewo **1-855-355-9800** oswa **1-855-358-5856** pou moun ki pa tande byen, 24 sou 24, 7 sou 7.

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