Western Health Advantage

# HIPAA Authorization for Use and Disclosure

## What does Health Information include?

Health information includes all personally identifiable information about your health care (also called Protected Health Information, or "PHI"). Please note that you may select various categories of information, such as medical information, health plan coverage, premium payments and claims status.

## What does authorization for use or disclosure mean?

Generally, you have the right to control your PHI. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA, also referred to as the "Privacy Rule"), WHA must obtain your written authorization for any use or disclosure of PHI that is not for treatment, payment or health care operations or otherwise permitted or required by the Privacy Rule. If you wish to share your PHI with a third party, please complete this form completely and return to WHA. You can set a termination date for this authorization and you may revoke the authorization. Please see detail in the attached form.

## Complete your Form Accurately

HIPAA requires specific information for an authorization form to be accepted. WHA prefers that you use our form, which is available at westernhealth.com/legal/privacy or you may call Customer Service at 888.563.2250; 711 TTY to request that a copy be sent to you.

Complete the entire form and do not forget to sign and date it. WHA will not be able to accept any unsigned and undated form.

## How do I submit this form?

Please complete the entire form, sign it and return it via mail, fax or in-person delivery:

| | |
|---|---|
| BY MAIL: | Western Health Advantage Mail Service<br>Attn: Member Services<br>P.O. Box 4457, Portland, OR 97208-4457<br>If mailing, use only the post office box address listed above |
| BY FAX: | Western Health Advantage<br>Attn: Member Services<br>916.678.5440 |
| TO DELIVER IN PERSON: | Western Health Advantage<br>2349 Gateway Oaks Drive, Suite 100<br>Sacramento, CA 95833 |

## How will I know if my request is processed?

WHA will review the completeness of the form you submitted. If all the required information are in the form, your request will be processed. If the form is incomplete, you will receive a call or letter advising you of the reason that we are unable to process it and where to submit the missing information.

# Authorization For Use or Disclosure of Health Information

Western Health Advantage

**Mail to:** Western Health Advantage Mail Service, Attn: Member Services
PO Box 4457, Portland, OR 97208-4457
**Fax to:** 916.678.5440
**Questions?** 916.563.2250 | 888.563.2250 toll-free | 711 TTY

## A. Use this form to authorize Western Health Advantage ("WHA") to use or to disclose your health information to another person or organization.

**1. Member whose information is to be disclosed**

Member Name (First Last) _____

Date of Birth _____

WHA ID _____

Address _____

**2. Person (the "Recipient") authorized to receive the Member's information**

Recipient's Name (First Last) _____

Relationship to Member _____

Recipient's Address _____

**3. Information to be disclosed to the Recipient (check only one of the three options)**

❑ All information that WHA maintains, excluding Sensitive Information unless specifically authorized in section 4.

**OR ❑ Only the following information, or types of information, WHA maintains:** (check all that apply)

❑ Medical Information (diagnosis, treatment, medication, including authorizations and referral status)

❑ Health Plan Coverage and Eligibility

❑ Financial/Billing Information (e.g. Premium payments), excluding claims information

❑ Claims Status/Payment Information

❑ Other _____

**OR ❑ Psychotherapy notes**

If you check this box, you may not check any of the other boxes in this section or in section 4. An authorization for the release of psychotherapy notes may not be combined with an authorization for disclosure of any other type of information; a separate form must be used.

**4. Is the Recipient also authorized to receive Sensitive Information as described below?**

❑ **NO** ❑ **YES** – If Yes, I specifically authorize WHA to release to Recipient:

❑ All sensitive information **OR** ❑ Only the following information: (check all that apply)

❑ Alcohol/substance abuse ❑ Mental health ❑ Genetic information

❑ Sexually transmitted illness (including HIV/AIDS)

❑ Sexual, physical, or mental abuse

❑ Abortion/reproductive health (including pregnancy, contraception)

5. **Reason for this authorization:** (check only one)

❑ Personal Use ❑ Legal

❑ Other (please specify): _____

6. **Authorization to Act on Member's Behalf**

I authorize the Recipient to perform the following acts:

❑ Enroll me/disenroll in/from Plan

❑ Choose/change my PCP

❑ Request new ID Card

❑ Change/correct missing/erroneous demographic information

❑ All of the above

## B. Expiration

This authorization will remain in effect:

❑ for one (1) year from the date of your signature below, **OR**

❑ until Month _____ Day _____ Year _____

(this period cannot be longer than 3 years from the date of signature below)

## C. Notice to Member

- You can revoke this authorization at any time by notifying WHA in writing. Revoking this authorization will not affect information WHA used or disclosed before receipt of the revocation request.
- WHA may not condition treatment, payment, enrollment in a health plan or eligibility for benefits on whether you or your representative sign this authorization.
- If this authorization is on behalf of a minor,
    - federal and state laws may prohibit WHA from acting on your request about Sensitive Information without written authorization from the minor 12 years of age or older;
    - it will expire when the minor turns 18 or is legally emancipated, or may be revoked by the legally capacitated minor.
- State law prohibits the re-disclosure of medical information by a Recipient without a separate authorization. If the requested information is re-disclosed, it may no longer be protected by federal privacy laws.
- If the requested information is Substance Abuse Information, this was disclosed from records protected by federal confidentiality rules. 42 CFR part 2 prohibits unauthorized disclosure of these records.
- You are entitled to a copy of this form.
- If you send a completed form by email to WHA, you acknowledge that it is not best practice to send protected health information through email that is not secure.

## D. Signature

I have read this form, and I understand and agree to its terms. I direct WHA to use or to disclose the information to the Recipient as directed above. I am signing this form of my own free will.

Signature _____ Date _____

Print Name _____

Relationship to Member (if applicable):_____

Personal or legal representatives or guardians: If this form is signed by someone other than the Member or the parent of a minor, this authorization must be accompanied by documentary proof of the authority to act on behalf of the Member (or the Member's estate).

Keep a copy of this Authorization for your records.

**WHA Internal Use Only**

Date Request Received _____ ❑ Identification Verified (documents checked)

Signature of Manager or Supervisor _____

Printed Name _____