healthfirst®
Health Insurance for New Yorkers

Authorization to Release Protected Health Information (PHI)

By completing or signing this form, I or my authorized party permit Healthfirst to share my PHI with the people or entities listed below. By Healthfirst, I also mean the company's subsidiaries, affiliates, employees, agents, and subcontractors. For help in completing this form, please read the instructions on pages 3–4. For any questions, please contact Member Services at the phone number indicated on your Member ID card.

A. Member Information

First Name: _____ Last Name: _____ M.I.: _____

Member ID #: _____ Birth Date: _____ Phone #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

B. Person or Entity that PHI Will Be Shared With

Please select which applies: ☐ Spouse ☐ Domestic Partner ☐ Adult Child ☐ Parent ☐ Other

Please complete the following information:

Individual or Entity Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Email: _____

C. Type of Information that Healthfirst is Authorized to Share

I authorize Healthfirst to share the following information:

The dates of the records subject to this authorization are _____ through _____

C1. Standard Health Plan Information:

☐ Claims and Related Appeals ☐ Billing/Enrollment ☐ Other _____

C2. Sensitive Information: *Sensitive information will not be shared unless I initial below:*

☐ HIV/AIDS _____ ☐ Mental Health _____ ☐ Reproductive Health/Family Planning Services _____
☐ Sexually Transmitted Infections (STIs) _____ ☐ **All sensitive information within subsection** _____

SUBSTANCE USE DISORDER (SUD): The Authorization to Release Substance Use Disorder (SUD) Protected Health Information (PHI) form must be used to submit requests for SUD-related information.

C3. Primary Care Physician (PCP) Changes:

☐ I permit Healthfirst to allow my authorized party to make PCP changes.

C4. Healthcare Billing/Payment:

☐ I permit Healthfirst to allow my authorized party to receive information related to my healthcare billing/payment matters in order to resolve a financial matter. I understand that this can include my health information.

C5. Care Management & Coordination of Care or Services:

☐ I permit Healthfirst to allow my authorized party to receive information related to my diagnosis, treatment of illness/condition, or coverage in order to appropriately coordinate my care, services, and/or benefits under my Healthfirst plan.

D. The Purpose of this Authorization

☐ At my request ☐ For the following purpose: _____

E. Expiration and Revocation

If an expiration date or event is not provided, this form will expire no later than twenty-four (24) months from the date it is signed.

This authorization will expire on:
☐ This specific date: _____ ☐ Once the following event occurs: _____

Right to Revoke: I may revoke this authorization form at any time. If I wish to do so, I can write to Healthfirst's Privacy Office either by mail to P.O. Box 5183, NY, NY 10274-5183, or by email at **HIPAAprivacy@healthfirst.org**. I understand it will not affect any action Healthfirst took before they received my revocation request.

F. Important Information I Need To Know

My signature below means that I understand and agree to the following:

- This authorization is voluntary and can be revoked at any time. My revocation will not affect any action Healthfirst took before they received my revocation request.
- My health information may be subject to re-disclosure by the recipient, and no longer protected by privacy regulations, if the organization or person authorized to receive the information is not a health plan or healthcare provider.
- Healthfirst cannot condition my treatment, payment, enrollment, or my eligibility for benefits and payment for services if I do not sign this form. However, without a valid form my request to release information to the individual(s) or entity(ies) named above cannot be fulfilled.

G. Member's or Authorized Party's Signature

G1. You must sign this form if:	G2. Minors must sign this form if *(check all applicable boxes)*:
1. ☐ you are the member, or the member's legal representative	1. ☐ you are married or emancipated
2. ☐ you are the parent or legal guardian of an unemancipated minor and the information shared does not pertain to a "sensitive" condition. See section C2 of this form for "sensitive" conditions.	2. ☐ you are unemancipated, are between the ages of 12 and 17, and the information authorized for release pertains to one of the following sensitive conditions: a. Mental Health b. Sexually Transmitted Infections (STIs) c. HIV/AIDS d. Reproductive/Family Planning (including contraception, prenatal care, and abortion)
Signature: _____	Signature: _____
Print Name: _____	Print Name: _____
Date: _____	Date: _____

NOTE: If the person signing this authorization form is not the member, please describe your relationship to the member and provide the relevant document permitting you to act on the member's behalf (e.g., power of attorney, guardianship, executor of estate, etc.).

Return this completed form and any relevant documentation to Healthfirst Member Services at:

P.O. Box 1566, New York, NY 10274-1566
Fax: 1-646-313-9059

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Authorization to Release Protected Health Information (PHI) – Instructions

A. Member Information

Be sure to fill this section out completely. For example, if you live in an apartment building, then include your apartment #. We will also need your Member ID # to find you in our system.

B. Person or Entity that PHI Will Be Shared With

Check the box that applies. Write the full name of the person or entity you want us to share your information with. Please don't use general terms like "my daughter" or "my son;" these will not be accepted. You need to be specific. If you permit this person or entity to receive a hard copy of your records, we will need his or her address as well.

Please understand that if you would like us to share your information with more than one individual or entity, a separate form must be filled out for each individual or entity you would like us to share your information with.

Information being sent by email will be encrypted. Please follow the instructions in the email you receive to access your information.

C. Type of Information that Healthfirst is Authorized to Share

C1. Indicate a date span for the information that we are permitted to share. This is not the same as the expiration date of the form (Section E). Then choose which **type of information** you want Healthfirst to share.

C2. **Sensitive information** will not be shared unless you specifically request it and initial right next to your selection. If you would like all sensitive information shared, then select and initial the last option.

SUBSTANCE USE DISORDER (SUD): **In order to comply with the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), the Authorization to Release Substance Use Disorder (SUD) Protected Health Information (PHI) form must be used to submit requests for SUD-related information.**

C3. Select this option if you permit Healthfirst to allow this individual or entity to make Primary Care Physician (PCP) changes to your account.

C4. Select this option if you permit Healthfirst to share healthcare billing/payment information with this individual or entity. Please understand that your health information may be shared with this individual/entity in order to address any billing/payment matters.

C5. Select this option if you permit Healthfirst to allow this individual or entity to participate in the management and coordination of your care. This may include talking with your care manager about your care/treatment and being involved in the decision making with regard to your care.

D. The Purpose of this Authorization

Please indicate why you want us to share your information with this individual or entity.

E. Expiration and Revocation

Be sure to include an **expiration date**. If you aren't sure of a date, it's OK. You can either select one of the other options or describe the event that will make this authorization form expire. However, in no event will it exceed twenty-four (24) months from the date the form is signed.

As a reminder, you can **revoke** (i.e., recall or reverse) this authorization at any time by simply writing to the Privacy Office at the address indicated on the form. However, it will not apply to the information already shared prior to our receipt of your revocation.

F. Important Information I Need To Know

It is important that you read the information in this section before signing this form. Not only does your signature allow us to share your information, it also means that you understand and permit the actions described within this part.

G. Member's or Authorized Party's Signature

G1.	G2.
1. If you are an adult member, or the member's legal representative/ guardian, check which box applies.	1. If you are a minor signing this form, check which box applies. Either you are an emancipated minor or you are a minor between the ages of 12 and 17 living in New York State and the information being shared is considered a "sensitive" condition. New York State law permits a minor to receive certain types of treatment without the consent of a parent or legal guardian if the services fall under one of the "sensitive" conditions described in G2 of the authorization form.
2. Adult member or legal representative/ guardian: Please sign and print your name; don't forget to include the date on which you signed the form.	2. You then must sign and print your name; don't forget to include the date on which you signed the form.
Please note that if you are the member signing this form, your name in this section must match the name used in Section A.	*Please note that if you are the member signing this form, your name in this section must match the name used in Section A.*

If you are signing this form on behalf of the member, you must provide the supporting documentation authorizing you to represent the member.

Examples of supporting documentation (i.e., legal documentation):

Power of Attorney	This legal document gives someone you trust authority to act on your behalf in healthcare billing/payment matters, amongst other authorities, if specifically indicated. Healthcare billing/payment matters can include your health information.
Executor of Estate	This legal document is used when the member is deceased and tasks an individual to handle the deceased member's estate/affairs.
Healthcare Proxy	This document gives someone you trust authority to make healthcare-related decisions if you are unable to make decisions or are incapacitated. **NOTE:** clinical documentation supporting the member's inability to make decisions must accompany the signed Healthcare Proxy form.
Guardianship	This court document gives a court-appointed individual authority to act on behalf of the member and to take care of the member, including property, healthcare, etc.

Unless otherwise directed, please return the completed form either by mail or fax to:

P.O. Box 1566, New York, NY 10274-1566
Fax: 1-646-313-9059