healthfirst
Health Insurance for New Yorkers

Authorization to Release Protected Health Information (PHI)

Do you want to give someone access to your health information?
Complete and sign this form and return it by mail, fax, or email. If you'd like help, call the Member Services phone number on your Healthfirst Member ID card.

Please sign this form or it can not be processed.

Section 1 Member Information

First Name		Middle Initial	Last Name
Member ID	Date of Birth (MM/DD/YYYY)		Phone Number
Mailing Address (include Apt., Bldg.)			
City		State	Zip Code
Email			

Section 2 Reason for this Authorization Request

○ For My Use ○ Other reason (please specify): ____________________

Section 3 Who are you sharing your information with? (Select all that apply.)

○ Spouse ○ Domestic Partner ○ Adult Child ○ Parent
○ Other (please specify): ____________________

Please complete the following information:

Individual or Entity Full Name		
Mailing Address (include Apt., Bldg.)		
City	State	Zip Code
Email	Phone Number	

Section 4 What info do you want to share?

Type of Information to be Released

1. Standard Information

☐ Claims and Related Appeals ☐ Billing/Enrollment
☐ Other (please specify): ____________________

2. Sensitive Information will not be released unless you specifically request it by checking the box and putting your initials in the space next to your selection:

☐ Mental Health ___________ ☐ Sexually Transmitted Infections (STI) ___________
☐ HIV/AIDS ___________ ☐ Reproductive Health/Family Planning Health ___________
☐ All sensitive information ___________

PLEASE NOTE: Per federal law, if you want to share information about substance use, you will need to complete a different form (Authorization to Release Substance Use Disorder (SUD) Protected Health Information form).

Date of Service

from____________________through____________________

Method of Disclosure

I want Healthfirst to release the above information by ○ mail **or** ○ email

Section 5 Expiration and Cancellation

This authorization will automatically expire 24 months from the date it is signed.
If you'd like it to expire sooner, tell us when:

○ Authorization should expire on ________/________/________ (MM/DD/YYYY)

○ **OR** once the following event occurs: ____________________

Right to Cancel: You may cancel this authorization form at any time. If you wish to do so, you 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**.

It will not affect any action Healthfirst took before they received your cancellation request.

Section 6 Before you sign…

Your signature means you understand and agree to the following:

This authorization is voluntary and can be cancelled by you at any time. If you do cancel it, it will not affect any action Healthfirst took before getting this request.

If the person or organization you authorize to receive your information is not a health plan or healthcare provider, then your information (with the exception of HIV/AIDS-related information) may no longer be protected by privacy regulations.

If you don't sign this form, it will not affect your treatment, payment or eligibility for benefits by Healthfirst; however, we won't be able to share your information.

Section 7 Please Note

Your signature is required if any of the below apply:

I am 18 years of age or older

I am a minor under the age of 18 and I am either married or I am emancipated

The information being disclosed pertains to drug or alcohol treatment

The information being disclosed pertains to one of the following conditions and my state allows me to be treated even if my parents or legal guardian do not agree with my decision:

- Mental health
- Sexually transmitted disease (including HIV/AIDS)
- Reproductive health (including contraception, prenatal care, and abortion)
- General medical and dental health

Section 8 Member's or Legal Representative's Signature

Please note: if you are the member signing this form, your name in this section must match Section 1.

Signature

Print Name ______________________

Date ______ / ______ / ______

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

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Return this signed, completed form and any relevant documentation to
Healthfirst Member Services
Mail: P.O. Box 5165, New York, NY 10274-5165
Fax: 1-212-801-3250
Email: **CCO-Member_Record_Request@healthfirst.org**

Don't forget to sign and date this form in Section 8.