healthfirst
Health Insurance for New Yorkers

Authorization to Release Protected Health Information (PHI) Instructions

Section 1 | Member Information

Be sure to fill this section out completely. For example, if you live in an apartment building, then include your apartment number. And be sure to include your Healthfirst Member ID so we can easily find you in our system.

Section 2 | The Purpose of this Authorization

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

Section 3 | Person or Entity that PHI Will Be Released to or Shared with

Write the full name of the person or entity you want us to release your information to or share it with. Please be specific: don't use general words like "my daughter" or "my son." If you permit this person or entity to receive a mailed copy of your records, we will need their address.

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 one.

Section 4 | Type of Information that Healthfirst is Authorized to Release or Share

Complete this section if you would like to select the specific type of information that you want Healthfirst to release to an authorized individual or entity.

Information being sent by email will be encrypted (sent securely). To view your information, please follow the instructions in the email you receive.

Section 5 | Expiration and Cancellation

Provide an expiration (end) date or describe what will make this authorization expire. You can write "until the end of my care" or "until I am no longer a member of Healthfirst" if you want to continue sharing your information with the person or persons you have chosen.

Section 6 | Important Information I Need to Know

It is important that you read the information in this section before signing this form.

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Section 7 | Member's or Authorized Party's Signature

Signature of Adult Member or Authorized Party	Signature of Minor Members
If you are the adult member or the authorized party signing this form, please check the correct box to indicate your relationship to the member. Sign and print your name, and don't forget to include the date.	If you are a minor signing this form, please check the correct box. Sign and print your name, and don't forget to include the date.

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

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 (for example, legal documentation)	
Power of Attorney	This legal document gives someone you trust permission to act on your behalf in healthcare billing/payment matters, which can include some health information. This individual cannot make healthcare decisions for you.
Executor of Estate	This legal document is used when the member (you) is deceased and tasks an individual to handle the deceased member's estate/affairs.
Healthcare Proxy	This document gives someone you trust permission to make healthcare-related decisions if you are unable to make decisions or are incapacitated. **NOTE:** clinical documentation supporting the member's (your) inability to make decisions must accompany the signed Healthcare Proxy form.
Guardianship	This document gives a court-appointed individual authority to act on behalf of the member (you) and to take care of them, including their property, healthcare, etc.

Mail, fax, or email this 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

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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, call the Member Services phone number on your Healthfirst Member ID card.

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 | The Purpose of this Authorization

Please select the reason for this authorization request.

☐ For My Use ☐ Other (please specify): _____

Section 3 | Person or Entity that PHI Will Be Released to or Shared with

Please check the box to indicate the person's or entity's relationship to you:

☐ 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 | Type of Information that Healthfirst is Authorized to Release or Share

Method of Disclosure: I want Healthfirst to release the following information by ☐ mail or ☐ email

Date of Service: from _____ through _____

Type of Information to be Released:

1. **Standard Health 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 (STIs) _____
   ☐ HIV/AIDS _____ ☐ Reproductive Health/Family Planning Health _____
   ☐ All sensitive information _____

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.

Section 5 | Expiration and Cancellation

This authorization will automatically expire 24 (twenty-four) months from the date it is signed. Or, please insert a date or event that will make it expire before 24 months.

☐ Authorization should expire on _____/_____/_____ (MM/DD/YYYY) or

☐ Once the following event occurs: _____

Right to Cancel: I may cancel 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 cancellation request.

Section 6 | 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 cancelled at any time. My cancellation will not affect any action Healthfirst took before they received my cancellation request.
- With the exception of HIV/AIDS, 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.

Section 7 | Member's or Authorized Party's Signature

Select the section that applies and sign your name.

Adult Member's or Authorized Party's Signature
(Check the box that applies)

☐ You are the member, or the member's legal representative (please circle): Power of Attorney, Proxy, Guardianship, Other: _____

☐ You are the parent or legal guardian of a minor and the information shared does **not** pertain 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 _____

Print Name _____

Date _____

Minor Member's Signature
(check all applicable boxes)

☐ You are married

☐ You are not emancipated, 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 _____

Print Name _____

Date _____

NOTE: If the person signing this authorization form is not the member, please provide the relevant document permitting you to act on the member's behalf (e.g., power of attorney, guardianship, executor of estate, etc.). Please see page 2 of the ***Authorization to Release Protected Health Information (PHI) Instructions*** **for examples of approved documentation.**

Return this 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

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Personal/Authorized Representative Request Form

[PLEASE PRINT]

This form identifies a person who has legal authority to act on a Healthfirst member's behalf in making decisions related to the member's healthcare. This provision applies to persons with legal guardianship, power of attorney, or other documented legal authority to act on behalf of a member. **Questions regarding this form should be directed to Healthfirst Member Services at the phone number on the Member ID card.**

Member Information (Include any letters in front of the identification number on the Member ID)

Name (First, Middle, Last, Title)	**Member ID Number**
Date of Birth (MM/DD/YYYY) _____/_____/_____	**Gender** ☐ Male ☐ Female ☐ Non-Binary
Address (including zip code)	
Home Telephone Number (including area code)	**Daytime Telephone Number** (including area code)
Email	

Personal Representative Information

Name (First, Middle, Last, Title)	**Personal/Authorized Rep. Mother's Maiden Name** (will be used for identity verification)
Address (including zip code)	**Telephone Number** (including area code)

A copy of a Power of Attorney or other legal document must be attached to this form in order for it to be processed. Attach supporting documentation and describe (e.g., Power of Attorney, Custodial Order, Executor of Estate).

Type of Documentation

Signature/Date (The member's legal Personal/Authorized Representative must sign and date this form for it to be processed.)

Print Name _____

Personal/Authorized Representative Signature _____ **Date** _____

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS

Important Information about Personal/Authorized Representatives

The federal Privacy Rule requires Healthfirst to follow certain procedures before it may provide access to your Protected Health Information (PHI) to someone other than you. PHI is information about you that can reasonably be used to identify you and that relates to your past, present, or future physical or mental health or condition, and the provision of healthcare to you or the payments for that care.

We will release PHI to your Personal/Authorized Representative upon receipt of a valid HIPAA authorization.

We will also recognize as a Personal/Authorized Representative an executor, administrator, or a person recognized by law as having authority to act on behalf of a deceased member or the member's estate.

Healthfirst will **not** treat someone as your Personal/Authorized Representative if we reasonably believe:

(1) you may be subject to domestic violence, abuse, or neglect by the Personal/Authorized Representative; (2) treating the person as your Personal/Authorized Representative could endanger you; or (3) in the exercise of professional judgment (for example, in a licensed professional's judgment), Healthfirst decides that it is not in your best interest to treat the person as your Personal/Authorized Representative.

A Personal/Authorized Representative designation will remain in effect until the member, a court order, or an applicable law revokes it.

To assist us in responding to this request, please complete this form by printing or typing into the spaces provided. Attach additional pages if necessary to clarify your request. Attach a copy of the document supporting your Personal/Authorized Representative's legal authority to act on your behalf.

Mail, fax, or email the completed form and supporting 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

If you have any questions about this form, please call the Member Services phone number on your Member ID card.

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS