healthfirst®
Health Insurance for New Yorkers

Authorization to Release Substance Use Disorder (SUD) Protected Health Information (PHI)

A. MEMBER INFORMATION

First Name: _____ Last Name: _____ MI: _____

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

Street Address: _____

City, State: _____ Zip Code: _____

B. AMOUNT AND KIND OF INFORMATION

I authorize Healthfirst to share my Substance Use Disorder (SUD) information as follows:

☐ All of my SUD information

☐ Only the following SUD records (be as specific as possible; for example, discharge summary only, labs only, paid claims only, authorizations only): _____

_____

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

C. WHO RECEIVES THIS INFORMATION

I authorize Healthfirst to share my SUD information as specified in this form with the following individual or entity:

Please select which applies: ☐ Provider ☐ Non-Treating Provider ☐ Other

Be as specific as possible here

Individual Name*: _____

Entity Name**: _____

Address: _____

Phone #: _____ Email: _____

*If you would like us to share your information with more than one individual or entity, please provide the same information for the additional recipients in Section I, which is on the back of this form.

**If the entity is a non-treating provider entity (e.g., law firm, life insurance, PPS), please indicate a specific individual's name to whom the information will be released.

D. WHY IS THIS INFORMATION BEING RELEASED

I authorize Healthfirst to share my SUD information for the following purpose (be as specific as possible):

_____

_____

_____

E. EXPIRATION AND REVOCATION

If an expiration date or event is not provided, this form will expire no later than 24 (twenty-four) 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 inform Healthfirst's Privacy Office either by mail sent to P.O. Box 5183, NY, NY 10274-5183, or by email at **HIPAAprivacy@healthfirst.org**. My revocation 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 my SUD records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164. My SUD information cannot be disclosed without my written consent unless otherwise provided for by the regulations.

G. MEMBER'S SIGNATURE OR AUTHORIZED PARTY'S SIGNATURE

You must sign this form if you are the member or the member's legal representative.

Signature: _____

Print Name: _____ Date: _____

If the person signing this authorization is not the member, please describe your relationship to the member (i.e., parent/legal guardian, legal representative, etc.):

_____

NOTE: If this authorization is being signed by the member's legal representative, you must provide the relevant legal document authorizing you to act on the member's behalf (e.g., power of attorney, legal guardianship, executor of estate).

H. WHERE TO SEND THE COMPLETED FORM

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

I. ADDITIONAL RECIPIENT INFORMATION (RELATED TO SECTION C)

Please select which applies: ☐ Provider ☐ Non-Treating Provider ☐ Other

Be as specific as possible here

Individual Name: _____

Entity Name**: _____

Address: _____

Phone #: _____ Email: _____

Please select which applies: ☐ Provider ☐ Non-Treating Provider ☐ Other

Be as specific as possible here

Individual Name: _____

Entity Name**: _____

Address: _____

Phone #: _____ Email: _____

Please select which applies: ☐ Provider ☐ Non-Treating Provider ☐ Other

Be as specific as possible here

Individual Name: _____

Entity Name**: _____

Address: _____

Phone #: _____ Email: _____

**If the entity is a non-treating provider entity (e.g., law firm, life insurance, PPS), please indicate a specific individual's name to whom the information will be released.