ASPIRUS HEALTH PLAN

MAIL OR FAX:
Attn: Customer Service
6105 Golden Hills Drive - Golden Valley, MN 55416
FAX: (763) 847-4010

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Directions: Complete each of the following sections below. This authorization is not valid or effective until you or your legally authorized representative complete each section, then sign, date and return the form. Your legally authorized representative must provide proof of his or her authority to act on your behalf. **Note:** This authorization does not affect or change the routine sharing of my health information by or between affiliates and/or any providers that is permitted or required under Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other applicable federal or state law. For questions about this form, please call Customer Service at 866.631.5404.

FULL NAME (FIRST, MIDDLE AND LAST):	PREVIOUS LAST NAME, IF ANY:

STREET ADDRESS	CITY	STATE:	ZIP CODE:

BIRTH DATE:	PHONE NUMBER:	MEMBER ID NUMBER:	EMPLOYER NAME AND GROUP NUMBER:

1. **Identify the Health Information that you authorize to be communicated, received, disclosed and used with others** *(Select one):* Your "Health Information," includes, but is not limited to your "protected health information" or "PHI" as defined by the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA") Your Health Information includes your past, present and future Health Information, and includes but is not limited to, medical and pharmacy claims records, and related case notes and information derived from them; and which specifically include, if Aspirus Health Plan has them, claims and case notes and information derived from them about HIV/AIDS, and mental health and substance use *(except see section 3 about psychotherapy notes and certain substance use information).*
   a. ☐ All of my Health Information (defined above) for all dates and periods of time.
   b. ☐ All of my Health Information (defined above) for the following specific date(s) or period(s) of time: _____
   _____
   c. ☐ Include for (check one) ☐ all dates and periods of time; or ☐ the following specific date(s) or period(s) of time: _____ only the following Health Information (describe below): _____
   _____
   _____
   _____

2. **Psychotherapy notes, or substance use disorder information derived from a treatment program or health care provider that receives federal funding.** Federal law requires specific consent for the release of this information. You must complete this section to authorize the communication of, receipt, disclosure and/or use any psychotherapy notes, or to authorize the communication, receipt, disclosure and/or use of certain substance use disorder information derived from a treatment program or health care provider that receives federal funding. Any information communicated, received, disclosed and/or used pursuant to this section 2 is your Health Information.

Psychotherapy Notes

   a. ☐ Include all psychotherapy notes.
   b. ☐ Include only psychotherapy notes for the following date(s)/time period: _____
   _____
   _____
   c. ☐ Include for (check one) ☐ all dates and periods of time; or ☐ the following specific date(s) or period(s) of time: _____ only the following psychotherapy notes (describe below): _____
   _____
   _____
   _____
   _____

Substance Use Disorder Information

   a. ☐ Include all substance use disorder information.
   b. ☐ Include only substance use disorder information notes for the following date(s)/time period: _____
   _____
   _____
   c. ☐ Include for (check one) ☐ all dates and periods of time; or ☐ the following specific date(s) or period(s) of time: _____ only the following substance use disorder information (describe below):
   _____
   _____
   _____
   _____

3. **Identify the person(s) and/or entity(ies) to whom or to which you authorize the communication, receipt, disclosure and/or use your Health Information** *(Provide complete name, relationship (if a family member), company name if applicable, address and phone number. Add an attachment if more space is needed.):*

a. Family member or legally authorized representative: _____

_____

_____

b. Provider and/or clinic: _____

_____

_____

c. Lawyer and/or law firm: _____

_____

_____

d. Other person or entity: _____

_____

_____

4. **Identify the reason for the release or disclosure or your Health Information:**

a. ☐ Member's request
b. ☐ Payment
c. ☐ Appeal of a denied claim
d. ☐ Legal/litigation
e. ☐ Other (explain): _____

_____

_____

5. **Identify the date this authorization expires** *(Select one)***:**

a. ☐ This authorization is effective until my health coverage under the above Member Number ends.
b. ☐ This authorization is effective for one year from the date I sign it.
c. ☐ This authorization is effective for less than one year from the date I sign it, and until _____

6. **Acknowledgements and Signature**

By executing this Authorization, I understand and agree that:

- This authorization allows the communication, receipt, disclosure, and/or use my Health Information (defined above).
- I have not been required to sign this form and am doing so voluntarily. I am not required to sign this form to receive health benefits.
- I may inspect or copy the Health Information that is released or disclosed.
- I may prospectively revoke this authorization at any time by contacting Customer Service at 866.631.5404. If I do revoke this authorization, it will only stop the release of Health Information in the future and does not apply to Health Information already released.
- Once it is released, the Health Information that is used or disclosed pursuant to this authorization is no longer protected by us or federal and state privacy laws. The recipient might re-disclose it.

Signature of Member: _____ **Date:** _____

Print Member Name: _____

Signature of Legally Authorized Representative*: _____ **Date:** _____

Print Name and Relationship to Member: _____

*If you are the member's legally authorized representative as defined by HIPAA or other applicable federal and state law, you must submit the applicable documentation or other proof of legally authorized representative status that establishes your authority including but not limited to:

Power of Attorney – *Valid power of attorney document* ***Guardian** – Valid court order appointing you as guardian* ***Executor** – Valid court order appointing you as executor of a decedent's estate. Legally authorized representatives must provide notice of any change to their status or authority.*

Date Received by _____ Initials _____ 8/2020

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