



Family and/or Friend

Authorization to Use and Disclose Protected Health Information

Form to be used if member wishes to allow release of information to a family member and/or friend.

SECTION A

Name (last, first, middle) _____ Subscriber number _____

Address _____

Telephone number () _____ Date of birth _____

MY HEALTH INFORMATION.

The health information that is subject to this Authorization consists of:

All health information about me created or received by Security Health Plan, including the following types of records: medical, alcohol and/or drug abuse, psychiatric/psychological (excluding psychotherapy notes*), developmental disabilities, case or medical management, billing, payment, claims and enrollment. It includes records of the diagnosis by a member of the medical profession of, or treatment for, acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC). It does not include any records of tests at anonymous counseling and testing sites or through the use of an anonymous home test kit to detect the presence of human immunodeficiency virus (HIV), antigen and non-antigenic products of HIV or antibody to HIV.

SECTION B

AUTHORIZED DISCLOSURE. I authorize Security Health Plan to disclose my health information described above to:

Name(s) _____ Relationship to member _____

()

Address _____ Telephone number _____

Name(s) _____ Relationship to member _____

()

Address _____ Telephone number _____

for the following specific purpose(s): payment matters, including claim handling, prior authorization requests, membership and enrollment inquiries; health care operations, including customer service, grievance or appeal matters, care coordination and additional purposes as described:

SECTION C

TERM. This Authorization will remain in effect until the following date or event occurs _____, or until I am no longer covered by Security Health Plan, unless I revoke this Authorization in writing (at any time) as described in the Security Health Plan Notice of Privacy Practices (copy available upon request).

I understand Security Health Plan will not condition my enrollment or eligibility for benefits on my providing this Authorization.

I understand that once Security Health Plan discloses my health information to the person named above in accordance with this Authorization, it is possible that the information could be redisclosed by that person and no longer protected by applicable federal and state law governing the use and disclosure of my health information.

* Psychotherapy notes are notes recorded by a mental health professional that document or analyze the conversation during a private, group, joint or family counseling session and that are separated from the rest of my medical record. Psychotherapy notes do not include medication prescription and monitoring, counseling session start and stop times, the types and frequencies of treatment, clinical test results, or any summary of diagnosis, functional status, treatment plan, symptoms, prognosis or progress to date.

SECTION D

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the disclosure of my health information. I knowingly and voluntarily authorize disclosure of my health information as described above.

Signature _____ Date _____

If member is unable to sign this Authorization, please complete the information below:

Signature of authorized legal guardian, health care agent, or other _____ Relationship _____ Date _____
authorized personal representative. (A copy of guardianship or other supporting documents must be provided to Security Health Plan)

Note to recipient of drug and alcohol abuse information: This information has been disclosed from records whose confidentiality is protected by federal law. Unless the records of the recipient are also subject to the federal law, the recipient is prohibited from further disclosure of this information without the specific written consent of the individual, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.