SecurityHealth Plan℠
Promises kept, plain and simple.®

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HIPAA Use and Disclose Protected Health Information Authorization

Form to be used if member wishes to allow release of information to a third party.

Sections A, B and D must be completed. A signature on page 2 is required to make the authorization valid.

Section A – Information about Security Health Plan member in question

Name (last, first, middle) _____ Subscriber no. _____

Address _____

Phone (_____) _____ Date of birth (m/d/y) _____ /_____ /_____

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, dental, 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.

* 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 B – Individuals who you want to have access to your information

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

Name(s) _____ Relationship to member _____

Address _____ Phone (_____) _____

Name(s) _____ Relationship to member _____

Address _____ Phone (_____) _____

Name(s) _____ Relationship to member _____

Address _____ Phone (_____) _____

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.

Additional names may be added to a separate page.

(continued)

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Section C – Term and other information

TERM. This authorization will remain in effect until the following date or event occurs

_____, (indicate a date/event or leave blank)
or until I am no longer covered by Security Health Plan, whichever occurs earlier, 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 my 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.

I understand that I will receive a copy of this signed authorization.

Section D – Signature

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 (m/d/y)**

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

_____ _____ _____ /_____ /_____
Signature of authorized legal guardian, health care agent, or other authorized personal representative **Relationship** **Date (m/d/y)**

(A copy of guardianship or other supporting documents must be provided to Security Health Plan if a signature appears here.)

Note to recipient of drug and alcohol abuse information: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Retain a copy of this authorization for your records.

Notice of Nondiscrimination
Security Health Plan of Wisconsin, Inc., complies with applicable federal civil rights laws and does not discriminate, exclude or treat people differently on the basis of race, color, national origin, religion, pregnancy and related conditions, sex (including sexual orientation, gender identity, sex stereotypes, sex characteristics and intersex traits), age, disability, health status, marital status, arrest or conviction record or military participation in the administration of the plan, including enrollment and benefit determinations.

Limited English Proficiency Language Services

ATTENTION: We have free interpreter services to answer any questions you may have about our health or drug plan.To get an interpreter, just call us at 1-877-998-0998 (TTY 711). Someone who speaks your preferred language can help you.This is a free service.

ATENCIÓN: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-998-0998 (TTY 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

LUS CEEV: Peb muaj kev pab txhais lus dawb los teb cov lus nug uas koj muaj txog peb txoj kev npaj khomob lossis tshuaj. Yog xav tau ib tug neeg txhais lus, tsuas yog hu rau peb ntawm 1-877-998-0998 (TTY 711). Ib tus neeg hais lus koj nyiam tuaj yeem pab koj. Qhov no yog ib qho kev pab dawb.

If you require materials in large print, call 1-877-998-0998 (TTY 711).

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