HealthTrust

Authorization to Release Protected Health Information

Part A: Information about the Covered Individual

Last Name:	First Name:		Email:	
Address:	City:	State:	ZIP Code:	Phone Number:
Date of Birth:	Covered Individual's relationship to person authorizing release of PHI (please check one): ☐ Self ☐ Parent ☐ Spouse ☐ Other: _____ (title or brief description)			

I, _____ (your name), authorize HealthTrust to provide information about the Covered Individual listed above to the person(s) listed below.

Information about the person you are authorizing to receive the information

Last Name:	First Name:		Email:	
Address:	City:	State:	ZIP Code:	Phone Number:
Recipient's relationship to the Covered Individual (please check one): ☐ Spouse ☐ Parent ☐ Employer ☐ Child ☐ Personal Representative ☐ Other: _____				

Part B: Information that can be released

I allow the following information to be released by HealthTrust on my or the Covered Individual's behalf:

Check only one box.

☐ All information. This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers, and financial information (like billing and banking). **This doesn't include sensitive information unless it is approved below.**

OR

☐ Only limited information may be released (check all boxes below that apply to you).

- ☐ Benefits and coverage
- ☐ Billing (premium contributions)
- ☐ Claims and payment
- ☐ Eligibility and enrollment
- ☐ Pre-certification and pre-authorization (for treatment approvals)
- ☐ Additional Information:_____

I also approve the release of the following types of sensitive information by HealthTrust (check all boxes that apply):

☐ All sensitive information

OR

☐ Just information about topics checked below

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Substance use disorder[1,2]
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Other:_____

1 Specify time period of records to be disclosed: _____

Description of records that may be disclosed:_____

2 Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by HealthTrust about me or the Covered Individual named above. I understand that my substance use disorder records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described in Part D. I understand that once this form has been used to disclose information there is no way to recall the information that has already been disclosed; by revoking or cancelling this approval after such a disclosure, I would be preventing additional future disclosures only, with no impact on previous disclosures.

Part C: Date your approval expires — Check only one box.

If this document was not already withdrawn, this approval will end on the earliest of the following dates:

☐ Upon termination of enrollment.

OR

☐ Upon the date, event or condition described below.

_____

Part D: Review and approval

I have read the contents of this form. I understand and agree that HealthTrust is allowed to release my information or that of the Covered Individual named above as I have stated above or as required by applicable law. I also affirm that signing this form is of my own free will. I understand that HealthTrust does not require that I sign this form in order for me to receive treatment or payment, or to enroll in or be eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to HealthTrust. I understand that withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be re-released by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Covered Individual signature or Designated Legal Representative/Guardian signature: Date (MM/DD/YYYY):

x

Part E: Designated Legal Representative/Guardian — Complete this section only if you have documentation supporting legal representation.

If this form is signed by someone other than the Covered Individual or parent, such as a personal representative, legal representative or guardian on behalf of the Covered Individual, please submit the following:

- A copy of a Health Care, General or Durable Power of Attorney.

  OR

- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the covered individual's behalf.

Please complete the following:

Legal representative (print full name):		Legal relationship to Covered Individual:
Legal representative street address:	City:	State: ZIP code:
Signature: x		Date (MM/DD/YYYY):

For recipient of substance use disorder information

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records 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 patient with a diagnosis of substance use disorder.

Part F: Submission

Please submit this form and any supporting documents to HealthTrust Enrollee Services through the Secure Enrollee Portal Message Center, (the most secure method), email at *enrolleeservices@healthtrustnh.org*, or via mail at PO Box 617, Concord, NH 03302-0617.

TO BE COMPLETED BY HEALTHTRUST STAFF MEMBER	
Name of HealthTrust Staff Member Receiving Form:	Date: