Sentara Health Plans

AUTHORIZATION TO RELEASE & OBTAIN PROTECTED HEALTH INFORMATION (PHI)

(This form is for a one-time release of information to a member and/or a third party.)

SECTION A: BASIC INFORMATION *Complete with information about the subject of the health records:*

Member Name: _____

Address: _____

Phone Number: _____ Date of Birth: _____ / _____ / _____

Member ID Number: _____ ID Number: _____

SECTION B: INSTRUCTIONS FOR ACCESS *Complete to provide specifics about the access requested:*

1. **What information is to be copied and released/reviewed?**

☐ Claims ☐ Eligibility/Benefits ☐ Case Management/Care Coordination

(Insert dates of service for information to be released) _____

I acknowledge that unless I check the following box, the information I am requesting to be used/disclosed may contain substance use disorder treatment, mental health, HIV/AIDs, or sexually transmitted infection (STI), or genetic testing information. ☐ I am NOT authorizing the release of the information listed in this paragraph.

2. **How would you like the record(s) delivered?**

☐ U.S. Postal Service ☐ Encrypted Email

3. **Where would you like your record(s) delivered?**

☐ To me (the member), at the address/email/fax listed above.

☐ To me (the member), at the following address/email/fax:

_____

☐ To a third party:

Name of person/organization: _____

Relationship and purpose: _____

Address: _____

Email: _____ Phone number: _____

Notice to party receiving drug/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**.**

Prohibition on redisclosure: The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse member. This information is confidential and protected by Federal Law. Any further redisclosure is strictly prohibited unless the patient provides specific written consent for the subsequent disclosure of this information. This authorization is subject to patient revocation at any time except to the extent that action has already been taken.

If not previously revoked, this consent will expire (check one): ☐ 30 days ☐ Other:_____
Specify Date or Event

I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form. I also understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by written notification. I understand that my revocation or modification of this authorization will not affect any actions taken by the entity in reliance on this authorization before it receives my request for revocation or modification. I must sign my written request and send it to Sentara Health Plans, Attention: Director of Compliance, PO Box 66189, Virginia Beach, VA 23466.

SECTION C: SIGNATURE

_____ _____
Signature of Member or Personal Representative (Ex. Guardian, Medical Power of Attorney) Date

_____ _____
Printed Name If Signed by Personal Representative, Specify Relationship to Member

RETURN FORM (SECTIONS A, B and C COMPLETED) TO:

Sentara Health Plans
Attention: Director of Compliance
PO Box 66189
Virginia Beach, VA 23466

or email: shpprivacy@sentara.com

Privacy Statement: Please be aware that email and text communication can be intercepted in transmission or misdirected.