Sentara Health Plans

AUTHORIZATION TO RELEASE & OBTAIN PROTECTED HEALTH INFORMATION (PHI)

(This form is used to request a copy of the member's health insurance record to be sent to the member and/or third party.)

SECTION A: MEMBER INFORMATION Member Name: _____

Address: _____

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

Member ID Number: _____ ID Number: _____

SECTION B: WHAT INFORMATION DO YOU WANT RELEASED/SHARED?

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

☐ Claims ☐ Eligibility ☐ Case Management/Care Coordination

Time period or date of information to be released. (*Dates must have already occurred. This is not for future dates):*

From_____(month/year) To _____ (month/year)

I acknowledge (understand) that the information I am requesting to be released (shared) may contain substance use disorder treatment, mental health, HIV/AIDs, sexually transmitted infection (STI), or genetic testing information. If you do not wish to release (share) this information, check the box below.

☐ I do NOT authorize the release of the information substance use disorder treatment, mental health, HIV/AIDs, sexually transmitted infection (STI), or genetic testing information.

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

☐ U.S. Postal Service ☐ Encrypted Email

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

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

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

_____

☐ To a third party (someone other than the member):

Name of person/organization: _____

Relationship and purpose: _____

Address: _____

Email: _____ Phone number: _____

_____

Notice to party receiving drug/alcohol abuse information*:* 42 CFR Part 2 prohibits unauthorized use or disclosure of these records.

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.

I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form. I understand that I have the right to receive a copy of this authorization. I understand I have a right to revoke (cancel) this authorization at any time by completing and sending a "Revocation of Authorization" Form" to Sentara Health Plans. I must sign my written request and send it to Sentara Health Plans, Attention: Director of Compliance, PO Box 66189, Virginia Beach, VA 23466.

A revocation (cancellation) of my authorization will not apply to any information that has previously been released (shared).

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.