Sentara Health Plans

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH PLAN INFORMATION
(Authorized representative)

This authorization will remain in effect until (a) the date you specify; (b) the date enrollment ends; or (c) the date you withdraw your permission.

**Mail this form to: Sentara Health Plans
Compliance
PO Box 66189
Virginia Beach, VA 23466
or email to: shpprivacy@sentara.com

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

Step 1: Complete the demographic information for the person receiving services.

1. _____ (Name)
2. _____ / _____ / _____ (Date of birth)
3. _____ (Member ID # or last four digits of SSN number)
4. _____ (Phone number (specify if mobile number))
5. _____ (Street address, city, state, and zip)

Step 2: Tell us what health plan information may be used or disclosed.

6. Check the appropriate box to indicate what information may be used or disclosed:

☐ Claims information ☐ Healthcare provider ☐ Address ☐ Account information

☐ Clinical information ☐ Other (see instructions) _____

Step 3: Tell us who you are authorizing to use or receive your health plan information.

7. _____ (Name of authorized person) _____ (Relationship to person receiving services)
8. _____ (Address of authorized person) _____ (Mobile phone number or email of authorized person)

9. OPTIONAL: Authorization termination date: _____ (Month) / _____ (Day) / _____ (Year)

Step 4: Complete and sign this authorization for substance use records

I acknowledge that information to be used or disclosed as a result of this Authorization may include records that are protected by other federal and/or state laws applicable to sexually transmitted diseases, mental health, and/or substance use. I SPECIFICALLY AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION RELATING TO SUBSTANCE USE. The recipient of substance use information disclosed as a result of this authorization will need my further written authorization to re-disclose this information. 42 CFR §2.32 restricts any use of this information to criminally investigate or prosecute any substance use patient.

10. _____ _____ / _____ / _____
Person receiving services or designated representative's signature** — Month / Day / Year

11. _____ _____ / _____ / _____
Parent/guardian signature (if required by state law) — Month / Day / Year

Step 5: Complete your acknowledgment that you understand that:

- You do not have to complete this authorization, and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits;
- The information used or disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws;
- You have a right to revoke this authorization at any time by completing and sending to Sentara Health Plans a "Revocation of Authorization" Form; provided however, revocation will not apply to any information that has already been released in response to this authorization; and
- You have a right to receive a copy of this signed authorization.

12. _____ _____ / _____ / _____
Person receiving services or designated representative's signature** — Month / Day / Year

13. _____ _____ / _____ / _____
Designated representative's relationship — Month / Day / Year

Attach a copy of the appropriate legal document granting authority if you have signed as the designated representative on behalf of the member

Sentara® Health Plans

INSTRUCTIONS FOR AUTHORIZATION COMPLETION

1. Do not skip any steps. Fill in all information as completely as possible.

2. Step 1, 1-5: This is **the member's** name, date of birth, Sentara Health Plans member number, phone number, and address.

3. Step 2, 6: This is the information you authorize Sentara Health Plans to disclose to your representative. The "other" section allows you to write in a specific description of the health plan information or name of the documents not on the checklist. Example: "Claims for Dr. Smith from 2/1/2009 to 2/1/2010."

4. Step 3, 7-8: This is the name and the address of the person whom you wish to have access to the member's information.

   Step 3, 9: This allows you to determine if and when you want this form to expire.

5. Step 4, 10-11: This is **the member's signature** or the signature of the person who has the legal authority to sign this type of document on behalf of the member. This section is for drug and substance use medical records.

6. Step 5, 12: This is **the member's signature** or the signature of the person who has the legal authority to sign this type of document on behalf of the member.

7. Step 5, 13: This is the relationship between the member and the person who has the legal authority to sign documents for the member. **ONLY** fill this line out **IF** someone other than the member signed the form.

Call Member Services if you have questions/concerns regarding this authorization form:

Employer Group and Individual & Family Plan members, call Member Services at the number on the back of your member ID card. You can also call our main number at 757-552-7401 or 1-877-552-7401 (TTY: 711), Monday–Friday, 8 a.m.–6 p.m.

Medicaid members, call 1-800-881-2166 (TTY: 711)
8 a.m.–8 p.m. | Monday–Friday

Sentara Community Complete (HMO D-SNP) members, call 1-866-650-1274 (TTY: 711)
All other Medicare members, call 1-800-927-6048 (TTY: 711)
October 1–March 31 | 7 days a week | 8 a.m.–8 p.m.
April 1–September 30 | Monday–Friday | 8 a.m.–8 p.m.