Sentara Health Plans

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION
(Designated 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 4 digits of SSN #)
4. _____ (Phone Number (specify if cell))
5. _____ (Street Address, City, State and Zip)

Step 2: Tell us what medical information may be used or disclosed

6. Check the appropriate box to indicate what information may be used/disclosed or changed:
   - ☐ Claims information ☐ PCP ☐ Address ☐ Change and/or correct account information
   - ☐ Clinical Information ☐ Other (see instructions) _____
7. Check the appropriate box to indicate the purpose of the use or disclosure:
   - ☐ At my request
   - ☐ Other (see instructions) _____

Step 3: Tell us who you are authorizing to use or receive your medical information

8. _____ (Name of Authorized Person) _____ (Relationship to Person Receiving Services)
9. _____ (Address of Authorized Person) _____ (Cell Phone Number or Email of Authorized Person)
10. OPTIONAL: Authorization termination date: _____ / _____ / _____ (Month / Day / Year)

Step 4: Complete and sign this authorization for alcohol and/or drug abuse 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 abuse. I SPECIFICALLY AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION RELATING TO DRUG AND/OR ALCOHOL ABUSE. The recipient of drug and/or alcohol abuse 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 alcohol or drug abuse patient.

11. _____ _____ / _____ / _____
Person Receiving Services or Designated Representative's Signature** — Month / Day / Year

12. _____ _____ / _____ / _____
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.

13. _____ _____ / _____ / _____
Person Receiving Services or Designated Representative's Signature** — Month / Day / Year

14. _____ _____ / _____ / _____
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 all information in as completely as possible.

2. Step 1, #1, #2, #3 & #4: This is **your** name, date of birth, last 4 digits of the social security number, or your Sentara Health Plans member number.

3. Step 2, #5: This is the information you want Sentara Health Plans to provide. The “other” section allows you to write in a specific description of the medical 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 2, #6: This is a description of the purpose for requesting Sentara Health Plans provide the information to someone else. Example: “Review of claims paid to Dr. Smith.”

5. Step 3, #7 & #8: This is the name and the address of the person who you wish to receive copies of the documents you are requesting.

6. Step 3, #9: This allows you to determine when you want this form to expire. If you do not put a date in, this authorization will expire in two (2) years from the date signed.

7. Step 4, #10: This is **your signature** or the signature of the person who has the authority to sign this type of document for you. This section is for Drug and Alcohol Abuse Medical Records.

8. Step 4, #11: This is the relationship between you and the person who has authority to sign documents for you. **ONLY** fill this line out **IF** someone other than you signed the form.

9. Step 5, #12: This is **your signature** or the signature of the person who has the authority to sign this type of document for you.

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

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

Employer Group and Individual & Family Plan members, call the 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).

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

Sentara Medicare
Sentara Community Care 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.