

Authorization for Disclosure of Health Information



This form is used to authorize the disclosure (sharing) of your protected health information (PHI). That means, by signing this form, you allow AmeriHealth Caritas New Hampshire to share your PHI with the person(s) or organization(s) you list below. You can also choose to allow those person(s) and organization(s) to share your PHI with us.

PHI is information that relates to your physical and/or mental health. It includes your health at every stage in your life. This includes your past, present, and future health. PHI may also relate to a specific health condition or health service you received. It includes all information regarding your health evaluations, diagnoses, treatments, and/or prescription records. Sharing this type of information may identify you to others. Federal and state laws limit the sharing of PHI in certain instances, including further sharing of information about substance or alcohol use except with the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

Even if you sign the form, you can still change your mind about sharing your PHI. Just let us know. You can tell us by mailing a letter to our office. Please include the date, your name, your member ID number, and your current address in the letter. Our mailing address is:

AmeriHealth Caritas New Hampshire
Consent Processing Center
P.O. Box 7092
London, KY 40742-7092

Once we receive the letter, we will stop sharing your PHI. However, we cannot take back any PHI we have already shared. If you have questions, contact Member Services by phone at **1-833-704-1177 (TTY: 1-855-534-6730)**.

Section A. Member information

Tell us the person whose PHI can be shared.

First name:		Middle initial:
Last name:	Member ID number:	
Date of birth (MM/DD/YYYY): / /		
Address line 1:		
Address line 2:		
City:	State:	ZIP code: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Home phone number (including area code): (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
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Email address:		

Section B. Recipient information

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Tell us the person or organization who can receive your PHI. You can attach more pages, if necessary.

Please tell us if the individuals and/or organizations listed below can also share your PHI with us: Yes No

First name of person or organization:		
Middle initial:	Last name:	
Home phone number (including area code): (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
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Address line 1:		
Address line 2:		
City:	State:	ZIP code: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Email address:		

First name of person or organization:		
Middle initial:	Last name:	
Home phone number (including area code): (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
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City:	State:	ZIP code: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Email address:		

First name of person or organization:		
Middle initial:	Last name:	
Home phone number (including area code): (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
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Address line 1:		
Address line 2:		
City:	State:	ZIP code: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Email address:		



Section C. Sharing of psychotherapy notes

Tell us if your psychotherapy notes can be shared. **(If you check “yes,” you may not check a box in Section D. You will need to fill out another copy of this form to authorize sharing of additional PHI in Section D.)**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides special protections for certain medical records known as “psychotherapy notes.” These are notes from a mental health professional about conversations during a counseling session. Federal law requires a separate authorization to share psychotherapy notes.

- No, do not share my psychotherapy notes.
- Yes, please share my psychotherapy notes.

Section D. Sharing of other PHI

Tell us what types of PHI can be shared. **You can check as many boxes as you want. At least one box must be selected.**

- Entire record.** All PHI related to the provision of and payment for my health care benefits and services. **This excludes psychotherapy notes.**
- Special records.** Some laws require you to give specific permission to share certain PHI. Please check the boxes below for PHI that is OK to share. By checking these boxes and writing your initials, you give permission for all your records containing that type of PHI to be shared. If you only want to authorize sharing of a subset of records, such as records about only one diagnosis, fill out the **Other record requests** section below.

<input type="checkbox"/> Genetic information	Initials:
<input type="checkbox"/> HIV/AIDS	Initials:
<input type="checkbox"/> Substance or alcohol use	Initials:
<input type="checkbox"/> Mental/behavioral health (including inpatient treatment)	Initials:

<input type="checkbox"/> Sexually transmitted disease	Initials:
<input type="checkbox"/> Abortion and family planning	Initials:
<input type="checkbox"/> Communicable diseases	Initials:
<input type="checkbox"/> Information you have asked us to treat confidentially	Initials:

- Other record requests.** In the box below, describe the PHI you want shared.

Examples:

- The claim related to my service on [date].
- Appeal information related to my claim on [date].

Please describe the information you want shared:



Section E. Purpose of sharing PHI

Tell us why you are releasing your PHI and how it may be used. **At least one box must be selected. If you request the sharing of genetic information to a Louisiana insurer, this authorization shall be invalid if used for any purpose other than as described below.**

<input type="checkbox"/> Care management/case management and coordination.	<input type="checkbox"/> Legal purposes.
<input type="checkbox"/> Billing or claims.	<input type="checkbox"/> School.
<input type="checkbox"/> Disability determination.	<input type="checkbox"/> Housing or other placement services.
<input type="checkbox"/> Employment.	<input type="checkbox"/> Other (please describe):
<input type="checkbox"/> Personal use.	

Section F. Expiration

Tell us when you want this form to expire. **At least one box must be selected.**

This authorization is effective immediately. But you can tell us when you want it to end. You can change this choice at any time.

- I want the authorization to expire one (1) year after my coverage with AmeriHealth Caritas New Hampshire ends.
- I want the authorization to expire on the following date, event, or condition: _____

*AmeriHealth Caritas New Hampshire must be notified of the event or condition to cancel or revoke this authorization. In New Hampshire, the authorization automatically expires two years after the date it was signed, unless you choose a date, event, or condition that occurs earlier. In North Carolina, the authorization automatically expires one year after the date it was signed, unless you choose a date, event, or condition that occurs earlier. If you are requesting the sharing of genetic information to a Louisiana insurer, the expiration date must be within 60 days after the date of the authorization. If you are requesting the sharing of mental health information in the District of Columbia, the expiration date must be within 365 days from the date of the authorization.

Section G. Rights and understandings

By signing below, you acknowledge that you have read and received a sufficient explanation of this document, and that you understand the following information and what you are authorizing us to do with your PHI:

- Any PHI shared according to your instructions in this authorization may be further shared by the recipient(s) and may no longer be protected by state or federal privacy regulations.
- You may revoke this authorization at any time. However, any action already taken cannot be reversed, and your revocation will not affect those actions. If you revoke this authorization, you should also tell the individuals and organizations listed in Section B.
- Signing this authorization to share PHI is voluntary and is not a condition of enrollment in AmeriHealth Caritas New Hampshire, eligibility for benefits, or payment of claims.
- Federal and state laws may allow us to charge a fee for copying records. You may be required to pre-pay for the copies. If not, your copies may be mailed with an invoice.
- You have the right to inspect the materials shared in accordance with this authorization.
- In some cases, federal and state law permit sharing of your PHI without an authorization. For more information, see our Notice of Privacy Practices.
- You can have a copy of this completed form.

If you need more information, please call Member Services at 1-833-704-1177 (TTY: 1-855-534-6730).



Section H. Approval

You or your personal representative must sign and date this form.

- I am the member.
- I am a parent. (Note: In some circumstances, documentation may be required.)

By signing below, I authorize the sharing of my PHI as described above.

Member first name:	Middle initial:	Last name:
Member signature:		Date (MM/DD/YYYY): / /

- I am the personal representative.

Signing for another person?

A personal representative is a person who has the legal authority to act on behalf of an individual. A copy of a power of attorney or other legal documentation must be on file at AmeriHealth Caritas New Hampshire or submitted with this form.

Personal representative first name:	Middle initial:
Last name:	
Description of representative's authority:	
Personal representative signature:	
Date (MM/DD/YYYY): / /	
Home phone number (including area code): (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Mobile phone number (including area code): (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Email address:	

Type of documentation you are attaching:	
<input type="checkbox"/> Power of attorney for health care decisions <input type="checkbox"/> Legal guardianship <input type="checkbox"/> Custodial order <input type="checkbox"/> Executor of estate	<input type="checkbox"/> Other (please specify):

Return the completed authorization form to:

AmeriHealth Caritas New Hampshire
 Consent Processing Center
 P.O. Box 7092
 London, KY 40742-7092



Addendum to Authorization for Disclosure of Health Information

Verbal consent

We, the undersigned, attest that the member identified in Section A above is **physically unable** to sign this authorization. Verbal consent does not replace the need for documentation showing that another person is the member's personal representative, and cannot replace this documentation simply because it is inconvenient for the member to sign.

Reason:

The signatures below indicate:

- The information on this form was communicated to the member.
- The member indicated their understanding of the information in this authorization.
- The member freely gave their consent.

Method of communication to member:

Phone In person Other (specify):

Witness printed name:

Witness printed name:

Witness signature:

Witness signature:

Date: / /

Date: / /

Discrimination is against the law

AmeriHealth Caritas New Hampshire complies with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of age, race, ethnicity, national origin or ancestry, mental or physical disability, sexual or affection orientation or preference, gender identity, marital status, genetic information, source of payment, sex, creed, religion, health or mental health status or history, need for health care services, amount payable to AmeriHealth Caritas New Hampshire on the basis of an eligible person's or member's actuarial class or pre-existing medical/health conditions, whether or not the member has executed an advance directive, or any other status protected by federal or state law.

AmeriHealth Caritas New Hampshire provides free aids and services to people with disabilities. Examples of these aids and services include qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services, such as qualified interpreters and information written in other languages, to people with limited English proficiency or whose primary language is not English.

If you need these services, contact AmeriHealth Caritas New Hampshire 24 hours a day, seven days a week, at 1-833-704-1177 (TTY 1-855-534-6730).

If you believe that AmeriHealth Caritas New Hampshire has failed to provide these services or has discriminated against you in another way, you or your authorized representative (if we have your written authorization on file) can file a grievance with:

- AmeriHealth Caritas New Hampshire Grievances
P.O. Box 7389
London, KY 40742-7389
1-833-704-1177 (TTY 1-855-534-6730)
- You can also file a grievance by phone at **1-833-704-1177 (TTY 1-855-534-6730)**. If you need help filing a grievance, AmeriHealth Caritas New Hampshire Member Services is available to help you. You can contact Member Services 24 hours a day, seven days a week, at **1-833-704-1177 (TTY 1-855-534-6730)**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019 (TDD 1-800-537-7697)

Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>.

Multi-language interpreter services

English — Attention: If you speak English, language assistance services, free of charge, are available to you. Call **1-833-704-1177** (TTY **1-855-534-6730**).

Spanish — Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-833-704-1177** (TTY **1-855-534-6730**).

French — Attention : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-833-704-1177** (TTY **1-855-534-6730**).

Chinese — 注意: 如果您使用中文, 我们可为您提供免费语言援助服务。请致电 **1-833-704-1177** (TTY **1-855-534-6730**)。

Nepali — ध्यान दिनुहोस्: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छन्। फोन गर्नुहोस्: **1-833-704-1177** (TTY **1-855-534-6730**)।

Vietnamese — Chú ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-833-704-1177** (TTY **1-855-534-6730**).

Portuguese — Atenção: Se você fala português, serviços de assistência linguística estão disponíveis gratuitamente. Ligue para **1-833-704-1177** (TTY **1-855-534-6730**).

Greek — Προσοχή: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-833-704-1177** (TTY **1-855-534-6730**).

Arabic — ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-833-704-1177** (TTY **1-855-534-6730**).

Serbo-Croatian — Pažnja: Ako govorite srpskohrvatski, besplatno su vam dostupne usluge jezičke pomoći. Nazovite **1-833-704-1177** (TTY **1-855-534-6730**).

Indonesian — Perhatian: Jika Anda berbicara dalam Bahasa Indonesia, layanan bantuan bahasa akan tersedia secara gratis. Hubungi **1-833-704-1177** (TTY **1-855-534-6730**).

Korean — 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-833-704-1177** (TTY **1-855-534-6730**)번으로 전화해 주십시오.

Russian — Внимание: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-833-704-1177** (TTY **1-855-534-6730**).

French Creole — Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-833-704-1177** (TTY **1-855-534-6730**).

Kirundi — Uragaba: Nimba uvuga Ikirundi, uzohabwa serivisi zigufasha mu ndimi ku buntu ata kiguzi. Terefona **1-833-704-1177** (TTY **1-855-534-6730**).

Polish — Uwaga: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-833-704-1177** (TTY **1-855-534-6730**).