Authorization to Release Information

As your insurance administrator, The Administrators, Inc. (TAI) resolves your coverage problems and claims issues with your insurance carrier/health plan. Beginning April 14, 2003 the attached Authorization Form is required by your carrier in order to allow them to release protected health information to TAI or another person or organization.

Please review and complete the form. A number of important points are highlighted here, for more detailed instructions please refer to the instructions on the back of the Authorization Form. If you have any questions please contact TAI's Enrollment and Customer Service Department at 800-634-4428.

Each section of the form must be completed; missing information will result in delays in processing the authorization.

- ☐ Include your Social Security/Insurance Card Identification Number
- ☐ In the "Recipient" section, list TAI as the authorized entity to whom you are authorizing your health plan to release information. Be sure to include our contact information:
  - TAI, 867 Sussex Blvd., Broomall, PA 19008, Phone 610-604-4500, Fax 610-604-4922.
- ☐ Review the "Description of the Information to be Released" section before completing.*
  - You should only check one of the three boxes listed.
  - If you select the "Psychotherapy Notes" box, you cannot check any other box.
  - If TAI routinely assists you with your health care, you should provide a "blanket" authorization to TAI by checking the second box that says "All information related to the provision of and payment for my health care benefits and services," and initial all applicable areas in the *Notes section.
  - Check the "Specific Information" box if an individual is assisting you in resolving a particular issue such as an appeal, and initial any/all applicable areas in the *Notes section.
  - A "Purpose of Release" must also be noted. To provide a "blanket" authorization to TAI write "To help with my health insurance services."
- ☐ An "Expiration" must be listed. But you can allow the authorization to remain in effect until you revoke it in writing by listing "Until I revoke this authorization." You may also indicate that the authorization will expire on a specific date or at the conclusion of an event, such as an appeal.
- ☐ You or your personal representative must sign the authorization. If a personal representative signs the authorization a copy of the legal documents must be submitted with the authorization.
- ☐ Return the completed Authorization Form to The Administrators, Inc. via fax at 610-604-4922 or mail 867 Sussex Boulevard, Broomall, PA 19008.

* If you wish TAI to provide all the services it currently provides without delay you should always: Check the box labeled "All information related to the provision of and payment for my health care benefits and services." Provide the Purpose of Release as "To help with my health insurance services." Write "Until I revoke this authorization" in the Expiration area.

Authorization to Release Information

[Please print]

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows the Health Plan (your health insurance carrier or HMO) to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to the Health Plan (contact Member Services for further instructions). Revoking this authorization will not affect any action taken prior to receipt of your written request.

Member Information: (individual whose information will be released)

Name: (First, Middle, Last, Title)		**Date of Birth:** (Month/Day/Year)
Address: (including zip code)		**Telephone Number:** (including area code)
Group Name/Number: (if available)	**Social Security Number:** (optional)	**Member ID Number:**

Health Plan: (organization that will release your information)

I authorize ____________________________ to release my protected health information as described below.
(Health Plan name on your ID card)

Recipient: (person or organization that will receive your information)

Person's Name or Organization:	**Telephone Number:** (including area code)
Address: (including zip code)	**Fax Number:** (if available)

Description of the Information to be Released: (what type of information will be released)

Check only one box:

❑ **Psychotherapy notes** – Federal law requires an authorization to use or release psychotherapy notes.
If you check this box, you may not check another box below.

❑ **All information related to the provision of and payment for my health care benefits or services.***

❑ **Specific information described below:***

____
Examples: The claim related to my service on (date); Appeal information related to my claim on (date)

Purpose of Release: ____
Examples: At my request; To resolve my appeal; To assist with my health insurance services

***NOTE**: State law requires that you give specific permission to release the information below even if you checked a box above. Indicate your permission for the Health Plan to release any of the following information by initialing all that apply.

Genetic Information	___________ (Initials)	**HIV/AIDS**	___________ (Initials)
Substance/Alcohol Abuse	___________ (Initials)	**Mental/Behavioral Health**	___________ (Initials)

Expiration: (when this authorization will end)

This authorization will expire on ____/____/____(mm/dd/yyyy) **OR** on the occurrence of the following event:

____
Examples: Until I revoke this authorization; Resolution of a specific issue

Approval: (You OR your personal representative must sign and date this form in order for it to be complete.)

I understand that this authorization to release information is voluntary and is not a condition of enrollment in this Health Plan, eligibility for benefits, or payment of claims. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws.

Member Signature: By signing below, I authorize the use of my protected health information.	**Personal Representative Information:** 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 court-related legal document must be on file at the health plan.
____________________ (Signature of Member)	____________________ (Printed Name of Personal Representative) ________ (Date) (____)________ (Telephone Number)
____________________ (Date)	____________________ (Signature of Personal Representative) ____________________ (Description of representative's authority)

PLEASE KEEP A COPY OF THIS FORM AND THE INSTRUCTIONS FOR YOUR RECORDS

[Please print}

Instructions - Authorization to Release Information

This form is used for you or your personal representative to authorize the Health Plan to release your protected health information to another person or organization at your request.

"Protected health information," means individually identifiable health information. It is information about you, including your name, address and medical information and may relate to your past, present or future physical or mental health or condition. The Health Plan maintains information that may include eligibility, benefits, claims or payment information.

Member Information: (individual whose information will be released)

Print your complete name, address, date-of-birth and telephone number. Provide your group name and number if available. Social Security number is optional.

Important: Provide the Member ID Number located on the front of your Health Plan identification card. Be sure to include any letters in front of the identification number.

Health Plan: (organization that will release your information)

The Health Plan is your insurance carrier or HMO that maintains information about you. Print the name of your Health Plan on the line provided.

Recipient: (person or organization that will receive your information)

The recipient is a person or organization that you choose to receive your protected health information from the Health Plan. You must provide all of the contact information in order for the information to be released.

- Identify the person, family member or organization to receive your information.
- Provide the contact information about the person, family member or organization

Description of the Information to be Released: (what type of information will be released)

You must indicate or describe the information to be released. **Check one box that best describes your request**. There are three choices. The first choice is **Psychotherapy Notes**. The second choice is **All Information**. The third choice is **Specific Information** that you must describe on the line provided.

If this authorization is to release psychotherapy notes, the Health Plan cannot release any other information unless you complete another Authorization to Release Information form.

Psychotherapy Notes are notes recorded by a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session. These notes are separated from the rest of the individual's medical record. **Psychotherapy notes cannot be combined with an authorization to release any other type of information.**

All Information. If you check this box the Health Plan may release all information related to the provision of a payment for my health care benefits or services. If someone is directly involved in coordinating your health care or benefits, you may want them to have access to all of your information.

Specific Information. By checking this box, you indicate that you want only specific information to be released. Describe the specific information on the line provided.

Purpose of Release. You must provide a brief description of the reason you want this information released. The statement, "At my request" is sufficient.

IMPORTANT: State law requires that you give specific permission to release certain health information. Your initials are required on each line in order for the Health Plan to release information for HIV/AIDS, Substance/Alcohol Abuse, Genetic information or Mental/Behavioral Health information.

Expiration: (when this authorization will end)

Print either an expiration date OR event, but not both. If an expiration event is used, the event must relate to the purpose of the release of information being authorized.

Approval: (You OR your personal representative must sign and date this form in order for it to be complete.)

Member Signature.	Personal Representative Information.
If you are the individual whose information will be released, you must sign and date in this section.	If you are the personal representative, the member's signature is not required. However, you must provide the requested information, signature and date. A copy of the legal authority, such as a Power of Attorney or other court-initiated document, must be on file with the Health Plan.

RETURN THIS FORM AS INSTRUCTED BY YOUR HEALTH PLAN