TIPS ON COMPLETING THE HEALTH ALLIANCE AUTHORIZATION FORM

Where it states "I hereby authorize Health Alliance to disclose my protected health information to," please list the name of the person(s) or organization(s) who you are allowing Health Alliance to disclose information to, their relationship to you, and their address and telephone number if different from yours. The individual(s) or organization(s) you list on the form is referred to as the "Authorized Person(s)."

The form states that ALL protected health information will be disclosed to the Authorized Person(s) unless you specify otherwise. You do not have to complete this section unless there is only specific information that you would like Health Alliance to disclose to the authorized person(s).

Please indicate whether the authorized person is allowed to change your primary care physician on your behalf, by checking the appropriate box.

The form states that the purpose of the disclosure is to comply with your request. If there is another purpose for the disclosure, please specify this purpose on the form; otherwise you do not have to complete this section.

In the boxed section on the first page, circle "No" for potentially sensitive protected health information you do not want Health Alliance to disclose to the Authorized Person(s).

The authorization form states your rights. Please read these rights carefully.

Where it states "This Authorization Expires," please check the appropriate box.

If a legal representative signs on your behalf, a legal document (i.e., Power of Attorney, Legal Guardian, Executor of Estate) must be on file or submitted with the Authorization Form.

When you have all the appropriate sections of the form completed, please mail it to Health Alliance, Attn: Privacy Officer, 301 S. Vine Street, Urbana IL 61801-3347 or fax to the Attn: Privacy Officer at 1-217-365-7494.

If you have any questions or additional concerns, you may contact a member of our Customer Service Department at the number listed on the back of your Member Identification Card or TTY at 711 or 1-800-526-0844 for the hearing impaired. Representatives are available from 8:00 a.m. to 5:00 p.m. Monday through Friday.

Health Alliance℠

MEMBER AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Member's Name _____ Birth Date_____

Street Address_____ Member #_____

City, State, Zip_____

Maiden/Other Names_____ Phone Number_____

I hereby authorize Health Alliance to disclose my protected health information to:
Name of person or organization (authorized person) and their relationship to you *(additional authorized person(s) may be added to the back of this form):*

Name		**Relationship**	
Address		**Phone #**	
City, State, Zip		**Alt Phone #**	

Name		**Relationship**	
Address		**Phone #**	
City, State, Zip		**Alt Phone #**	

Name		**Relationship**	
Address		**Phone #**	
City, State, Zip		**Alt Phone #**	

All protected health information may be disclosed to the authorized person stated above, unless I otherwise specify below.

_____

Authorized person(s) is allowed to change my Primary Care Physician. Yes ☐ No ☐ (*check one*)

The purpose of this disclosure is to comply with your request. If there is another purpose for the disclosure, please specify below.

_____

Disclosure is also authorized for the following protected health information unless you circle 'No.'

No	• Communicable disease and infection information, as defined by statute and Illinois Department of Public Health rules (which include venereal disease, "VD," tuberculosis, "TB," hepatitis B, human immunodeficiency virus "HIV," acquired immunodeficiency "AIDS," and AIDS related complex "ARC," and specify other if known)_____
No	• Alcohol and/or drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations, Part 2. (See "**Important Notice**" on next page.)
No	• Mental health treatment records, psychological services and social services information, including communications made by me to a social worker or mental health professional.

I have read and I understand and acknowledge the following statements about my rights:

- I may revoke this authorization at any time prior to the expiration date by notifying Health Alliance in writing. However, the revocation will not have any effect on actions taken before the revocation was received.
- If the person or organization to whom this information is disclosed is not a covered entity under the federal privacy rules, the information may no longer be protected by the federal privacy rules after such disclosure is made.
- Treatment, payment, eligibility or enrollment will not be conditioned on obtaining this authorization except as specifically authorized by law.

This authorization expires (*check one*):

☐ One Year
☐ Life of the Policy
☐ Upon the following specific date, event or condition (*please add information below*):

_____

I accept these terms and authorize disclosure of my protected health information as stated on this form (*dependents age 18 and over must sign below*):

_____ _____
Member Signature Date

_____
Printed Name of Member

If a legal representative signs on behalf of the member, Health Alliance must have a copy of the legal document declaring representation on file (i.e., Power of Attorney, Legal Guardian, Executor of Estate). If a legal document declaring representation has not been submitted, please submit a copy with this form.

_____ _____
Legally Authorized Representatives Signature Date

_____
Printed Name of Legally Authorized Representative

IMPORTANT NOTICE: ANY INFORMATION DISCLOSED IS PROTECTED BY FEDERAL PROTECTION RULES (42 CFR. CH. I, PART 2) AND STATE MENTAL HEALTH PROTECTION LAWS AND IS PROHIBITED FROM FURTHER DISCLOSURE UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN AUTHORIZATION OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHORIZATION FOR RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. FEDERAL RULES RESTRICT USE OF THE INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY MEMBER RECEIVING TREATMENT FOR ALCOHOL OR DRUG ABUSE.