# AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

*Complete all sections, date, and sign*

## I. AUTHORIZATION

I, ________________________________, hereby voluntarily authorize the disclosure of information from my health record.
*(Name of Member / Patient)*

| II. MEMBER / PATIENT INFORMATION: | III. INFORMATION IS TO BE PROVIDED TO: |
| --- | --- |
| NAME OF MEMBER / PATIENT | NAME OF PERSON OR ENTITY |
| DATE OF BIRTH *(MM-DD-YYYY)* | COMPANY (If Applicable) |
| MAILING ADDRESS *(CITY)* *(STATE)* *(ZIP CODE)* | MAILING ADDRESS *(CITY)* *(STATE)* *(ZIP CODE)* |
| PHONE NUMBER<br>(     ) | Is the Subscriber different than the Member / Patient?<br>*Examples include:*<br>*A spouse or domestic partner who is covered under their partner's plan*<br>*A dependent covered under their guardian or parent's plan*<br>Yes ☐ No ☐ |
| EMAIL ADDRESS | |
| MEMBER ID NUMBER (Found on Member Card) | SUBSCRIBER NAME **(Fill out if Answered Yes Above)** |

## IV. THE PURPOSE OR NEED FOR THIS DISCLOSURE IS:

☐ At the request of the member/patient

☐ Other (Specify) ________________________________

## V. THE INFORMATION TO BE DISCLOSED: **(Check All That Apply)**

☐ Entire Record (Includes all of the below)
☐ Case Management
☐ Claims
☐ Eligibility / Benefits
☐ Medical Records
☐ Other (Specify): ________________________________

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Substance Use Disorder Treatment/Referral
☐ Mental Health
☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases

## VI. AUTHORIZATION

I understand that I may revoke this authorization in writing submitted at any time to member services, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated, or unless otherwise required by law.

_______________________________________________

*(Specify a date (mm/dd/yyyy) or expiration event)*

I understand that XO Health will not condition treatment or eligibility for case on my providing of this authorization.

I understand that information disclosed by their authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2 (see below), may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

| SIGNATURE OF MEMBER/PATIENT OR REPRESENTATIVE *(State Relationship if Applicable)* | DATE *(mm/dd/yyyy)* |
|---|---|
| | |

**Return the completed form to member services by mail or fax**

| **Mailing Address** | **Fax Number** |
|---|---|
| XO Health Member Services<br>565 Willowbrook Center Pkwy.<br>Willowbrook, IL 60527 | 404-924-6309 |