XO Health

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

Full Name of Member/Patient		
Birth Date (MM/DD/YYYY)		
Address		
City	**State**	**ZIP Code**
Phone Number		
Email Address		
XO Health Member ID Number (Found on Member ID Card)		

III. Information Is To Be Provided To

Name of Person or Entity		
Company (If Applicable)		
Address		
City	**State**	**ZIP Code**

Is the Subscriber different than the Member/Patient?

Examples Include:
- A Spouse or Domestic Partner who is covered under their partner's plan
- A Dependent covered under their guardian or parent's plan

☐ **Yes** ☐ **No**

Subscriber's Name (Fill out if you 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**

☐ **Other** (Specify) _____

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V. The Information To Be Disclosed (cont.)

(Check All That Apply)

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

- ☐ **Substance Use Disorder Treatment/Referral**
- ☐ **HIV/AIDS-related Treatment**
- ☐ **Mental Health**
- ☐ **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 If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated, or unless otherwise required by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]*.

Member/Patient or Authorized Representative Signature (State Relationship, If Applicable)	**Date** (MM/DD/YYYY)

Return The Completed Form To Member Services By Mail Or Fax

Mailing Address:

XO Health Member Services
565 Willowbrook Center Pkwy.
Willowbrook, IL 60527

Fax Number:

(404) 924-6309