XO Health

Authorization For Use Or Disclosure Of Protected Health Information

I. Authorization

Fill out the requested details (your full name) for the plan member who is requesting an authorized representative to have access to their medical information.

II. Member/Patient Information

Your full name, birth date, address (street, city, state, ZIP code), phone number, email address, and XO Health Member ID Number (found on your Member ID Card).

III. Information Is To Be Provided To

Fill out the requested details (name, company if applicable, address) for the person or entity that will be designated as the authorized representative and will have access to the medical information specified in Section V.

Answer if the Subscriber is different than the Member/Patient (e.g., a spouse or dependent). If "Yes," provide the Subscriber's Name.

IV. The Purpose Or Need For This Disclosure Is

Check the box that best describes why you are requesting this disclosure ("At the request of the Member/Patient," "Case Management," or "Other"). **If you select** "Other," please provide a specific reason.

V. The Information To Be Disclosed

Check the box(es) corresponding to the type(s) of health information you want to be disclosed ("Entire Record," "Claims," or "Other"). If you select "Other," please specify.

If you wish to disclose any of the listed sensitive information (Substance Use Disorder Treatment/Referral, Mental Health, HIV/AIDS-related Treatment, Sexually Transmitted Diseases), you must check the corresponding box(es).

VI. Authorization (Please Read Carefully)

You can cancel (revoke) this authorization in writing at any time, unless action has already been taken based on it.

This authorization will end one year from your signature date unless you specify a different expiration date or event, or if law requires otherwise.

XO Health will not base your treatment or eligibility for care on whether you provide this authorization.

Once your information is disclosed as you've authorized, it may be shared further by the recipient outside of XO Health's control and may no longer be protected by certain federal privacy laws (with specific exceptions for Alcohol and Drug Abuse information).

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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 Authorized Representative (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** (Optional)

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