

**AUTHORIZATION TO SHARE MY PROTECTED HEALTH INFORMATION**  
**Making HIPAA as Easy as 1, 2, 3 – and 4, 5, 6!**

**Five Letters That Protect Your Privacy:** Your privacy has always been very important to us and the federal government recently created HIPAA laws to protect how and when your health care and personal information can be shared.

If you'd like Excellus Health Plan, Inc. and Support Services Alliance, Inc. (SSA) to share information about you with people or other organizations, please complete this form. This includes sharing information with a spouse, friend, or even a parent if you are over the age 18. Giving your consent to share your personal information is as easy as 1, 2, 3- and 4, 5, 6 by completing the six sections of this brief form. For your convenience, you can use this form to authorize our disclosure of your information to more than one person. However, each person you identify will have the same access to your information. If you would like each person to access *different* information or to have access to your information for a *different* period of time, you'll need to complete separate forms for each individual or time period. A little extra paperwork, but protecting your privacy is worth a few minutes of your time! Please remember that to provide you with quality service, we will continue to communicate our payment activities in connection with your claims, your enrollment in our health plan or your eligibility for benefits to providers of care involved in your treatment.

**Important Note:** There are state and federal laws that contain special protection for certain conditions. These conditions are genetic testing, alcohol or substance abuse, mental health, abortion, sexually transmitted diseases and HIV/AIDS. If you would like us to share information with other people or organizations on one of these protected diagnoses, please clearly state this below in Step 2 in the second option regarding specific information. In order for us to release information about a minor regarding abortion, sexually transmitted diseases or substance abuse the minor must complete the authorization – even to disclose information to a parent. If you would like to authorize us to release information regarding HIV/AIDS, a different form needs to be completed. We ask that you contact our office at the telephone number on your identification card, for this form.

Your authorization is completely voluntary and you don't have to sign this form. We will not condition our payment activities in connection with your claims, your enrollment in our health plan or your eligibility for benefits on you giving this authorization. If additional forms are needed you may copy this form, or contact our office at the telephone number listed on your identification card.

Please check here if you would like to authorize access to psychotherapy notes. If this box is checked, then this authorization cannot be used for another reason. If checked, steps two and three below can be skipped.

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**Please be sure to provide us with all of the following information.**

**Step 1: Tell Us Who You Are:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Subscriber ID Number as listed on your identification card: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

( ) Check here if you have covered dependent children under the age of 18 and wish us to also disclose information related to your children (other than the certain medical conditions explained above).

Name \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Step 2: Tell Us Why You'd Like Us to Share Your Information**

So Excellus Health Plan & SSA can:

- Respond to all requests for confidential information about me made by the individual(s) or organization(s) I list below.
- Respond to requests for only the following specific information (such as claims by a specific provider or information related to one of the protected diagnosis listed above).

*Please specify:* \_\_\_\_\_

- Respond to inquiries related to a specific date of service:

*Please specify:* \_\_\_\_\_

**Step 3: Tell Us What Specific Information You'd Like Us to Share:** Please list the specific protected health information you wish us to disclose. **Please check all that apply:**

- My claim information (e.g. status, type of service, diagnosis, provider, dates of service, etc.)
- My membership information (e.g. coverage information, enrollment dates, eligibility, address, dates of birth, etc.)
- My benefit information (e.g. benefits available, benefits used, contract limits, etc.)
- My medical records (e.g. physician or hospital records, case management, etc.)
- Other information (please specify): \_\_\_\_\_
- Please exclude the following information: \_\_\_\_\_

**Step 4: Tell Us With Whom You'd Like Us to Share Your Information:** Please list the person(s) and/or organizations with whom you want us to share the information described above. Please remember if you'd like us to share information with more than one person, the information to be disclosed and the expiration date must be the same for each person.

**Name/Organization**

**Address**

Support Services Alliance, Inc. (SSA)

PO Box 130, 107 Prospect St., Schoharie, NY 12157

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**Step 5: Tell Us When You'd Like Us to Share Your Information:**

Please share my protected health information during the time period(s) below:

- Until Excellus Health Plan & SSA completes the activities outlined in section 2.
- Until I send Excellus Health Plan or SSA a form canceling my authorization.
- From \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_

**Step 6 (the last one!): Please Give Us Your Signature:**

To give Excellus Health Plan & SSA your consent to share the protected health information noted above, please print your name on the line below and then provide your signature and today's date.

I, (please print name here) \_\_\_\_\_, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I confirm my authorization for the use, request and release of my confidential member information as described in this form. I understand that I may cancel this authorization at any time by completing an authorization revocation form and sending it to the address below. I also understand that the revocation of this authorization will not take effect until SSA or Excellus Health Plan received my authorization cancellation form.

I understand that, if the person(s) or organization(s) I authorize to receive information described in this form is not a health plan, covered provider or health care clearinghouse subject to federal health information privacy laws, s/he may further disclose the information and it may no longer be protected by those laws.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Member or Personal Representative

If this request is by a personal representative on behalf of our member, please give us the following information:

Personal Representative's Name: *(please print)* \_\_\_\_\_

Description of Personal Representative's Authority (a power of attorney, legal guardian or state executor):

\_\_\_\_\_

***Please note: personal representatives must provide legal proof of representation, such as power of attorney documentation.***

**Please complete and return this form to:**

SSA  
PO Box 130  
Schoharie, NY 12157  
Fax: 518-295-8556

**PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS**

## **Tips for Completing the Authorization to Disclose Protected Health Information Form**

- **Psychotherapy Notes** – If you would like another person or organization to have access to psychotherapy notes (when applicable), this box must be checked. In the event that this form is being used for this purpose, it cannot be used as authorization to disclose any other type of information. Therefore, if checking this box, you should disregard sections 2 and 3 of the form.
- **The Individual (Section 1)** – This is the name, address, identification number and date of birth of the member authorizing us to disclose information. If the member is covered by more than one health insurance contract with our company, and wishes to allow us to disclose under both contracts, please indicate both member identification numbers. If applicable, you can also use this area to allow us to disclose information related to your covered dependents under the age of 18. We cannot however disclose information on genetic testing, alcohol or substance abuse, mental health, abortion, sexually transmitted diseases and HIV/AIDS without the consent of your dependent(s). The authorization would be invalid as of the child's 18<sup>th</sup> birthday.
- **Purpose of this Authorization (Section 2)** – If you choose, you can limit the reason for disclosing information. For example, if you would like us to disclose information related to a particular surgery or date of service, you would check the box labeled "specific medical condition or service date(s)", and indicate the specific reason in the space provided. If you would like us to disclose information for any reason, please check *Any Purpose*. If you would like us to disclose information regarding one of the protected diagnoses listed on the authorization this **must** be clearly stated in this section. Checking Any Purpose will not permit disclosure of information regarding protected diagnoses.
- **Protected Health Information to be Disclosed (Section 3)** – If you choose, you can limit the information we disclose. For example, if you would like only your membership information (e.g. address, effective/termination dates of coverage, etc.) disclosed, you would check only the box labeled Membership Information. If you would like to exclude specific information, e.g. everything except address, you can request that by checking the box that indicates *Exclude the following information*.
- **Entity Authorized to Receive Information (Section 4)** – This is the name and address of the person or organization to whom you are allowing us to disclose your protected health information e.g. spouse, parent (for child age 18 or over), neighbor, employer group benefit administrator, immigrant assistance center, etc.
- **Expiration (Section 5)** – This is the date you choose at which time the authorization will no longer be valid. Completion of requested disclosure refers to Section 2 of this form. If you have indicated a specific condition, service or event, this authorization will no longer be valid once that condition, service or event is finalized.
- **Signature (Section 6)** – You must sign and date the form in order for it to be valid. If a personal representative is signing and dating this form we must have proof of the relationship giving the person the power to act as your representative. For example, if someone is given Power of Attorney (which must specify that the person can receive information related to insurance transactions or have access to medical information), we must have a copy of the Power of Attorney. The signed form must also indicate the description of the personal representative's authority to act on behalf of the individual, e.g. Power of Attorney. **If you have listed dependent children under the age of 18 in section 1, you must complete the personal representative section.**