

## Authorization to Disclose Protected Health Information (PHI)

Under Federal and State privacy laws, Nova Healthcare Administrators, Inc., Independent Health and/or Pharmacy Benefit Dimensions, LLC (individually or collectively herein "Company") is authorized to use or disclose your health information for payment, treatment and health care operations and as required by law. For uses and disclosures other than these purposes, your written authorization is required before sharing your health information. This includes sharing your health information with your spouse, relatives, employer, etc. This form allows you to authorize the Company to use or disclose your health information including HIV-related information to those individuals or entities you specify.

### Please read before completing this form

- Incomplete authorizations will be considered invalid and will not be accepted. Incomplete authorizations will be returned. **An asterisk (\*) is used to denote the required fields in this form.**
- Completion of this authorization form is voluntary. You may refuse to sign this form, but then Company will not be able to release your information.
- A copy of this authorization will be available to you, but you should retain a copy for your records.
- Signing or not signing this form will not affect any payment, enrollment or eligibility for benefit decisions made by Company.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described in this authorization may be disclosed to other individuals or institutions and no longer protected by these regulations.
- You may revoke this authorization in writing at any time by sending a letter to the address listed below. Your revocation notice will not apply to actions taken by the requesting person/entity prior to the date we received your written request to revoke this authorization.

#### Send completed and signed authorization to:

Nova Healthcare Administrators  
P.O. Box 408  
Buffalo, NY 14231  
Fax: (716) 250-7193  
memberservice@novahealthcare.com

**If you need assistance completing this form, please contact Nova  
using the number listed on your ID card or email  
memberservice@novahealthcare.com.**

## Authorization to Disclose Protected Health Information (PHI)

Section A: Member Information*			
Name*:	Date of Birth*: / /	Member ID*: _____ - _____	

  

Section B: Authorized Individuals* (at least one individual is required)			
Please list the individuals and/or entities that you are authorizing to view or receive your health information. If more space is required to list individuals or entities, please attach an additional page.			
1.	Name*:	Relationship*:	Telephone Number*: (    )
2.	Name:	Relationship:	Telephone Number: (    )
3.	Name:	Relationship:	Telephone Number: (    )

  

Section C: Information That Can Be Released (Select C-1 or C-2 and if applicable, C-3)*	
If more space is needed to describe the information that can be released, please attach an additional page.	
<input type="checkbox"/>	<b>C-1: I would like you to disclose any of my health information requested by the individuals and/or entities named in Section B. This does <u>not</u> include information in Part C-3 (below) unless I have placed my initials next to the condition. If I do not place my initials in C-3, information related to those conditions will not be disclosed.</b>
- OR -	
<input type="checkbox"/>	<b>C-2: Only the following specific health information</b> (such as claims submitted by a specific provider or information related to one of the protected diagnoses listed below):  <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px;"></div>
- AND, IF APPLICABLE -	
<b>C-3:</b> Unless specifically initialed below, I understand my health information will <u>not</u> be disclosed related to the following conditions. By placing my initials next to one or more of these conditions, I am authorizing Company to disclose information related to the condition(s) (see page 4 for additional information):  <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <div style="margin-bottom: 10px;">_____ Alcohol and/or Substance Abuse</div> <div style="margin-bottom: 10px;">_____ Pregnancy/Reproductive</div> <div style="margin-bottom: 10px;">_____ Sexually Transmitted Diseases</div> </div> <div style="width: 45%;"> <div style="margin-bottom: 10px;">_____ HIV-Related</div> <div style="margin-bottom: 10px;">_____ Mental Health</div> <div style="margin-bottom: 10px;">_____ Genetic Testing</div> </div> </div>	

**Section D: Purpose and Time Period**

Unless noted below, the authorized parties in Section B can obtain your health information upon their request and from the start date of your plan coverage.

- ☐ Purpose: \_\_\_\_\_
- ☐ Time Period: Only release health information concerning dates of service from *(insert date)* \_\_\_\_\_ to *(insert date)* \_\_\_\_\_.

**Section E: Expiration**

This authorization will automatically expire one (1) year after termination of your enrollment, upon your death, in the case of a minor, when the named minor reaches the age of eighteen (18) years, or if Company receives a letter from you revoking this authorization.

For dates or events not described in the preceding paragraph, you may specify an expiration date or event for this authorization below:

This authorization will expire:

- ☐ On the following date *(insert date)*: \_\_\_\_\_
- ☐ On the following event: *(please specify)* \_\_\_\_\_

**Section F: Personal Representative Information**

Complete this section if you are a personal representative that is acting on behalf of a member. You must include a copy of one of the following documents as proof of your legal representation and authority:

- ☐ Valid health care proxy
- ☐ Certificate of guardianship issued by a Court of appropriate jurisdiction
- ☐ Surrogate decision maker appointed pursuant to Family Health Care Decisions Act (FHCDA)

If the member is deceased, please submit a copy of one of the following:

- ☐ Letters of Administration or Letters Testamentary

<b>Name:</b>	<b>Relationship:</b>	<b>Telephone Number:</b> (     )
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**Section G: Signature/Date\***

Please read the following carefully before you sign, and refer to page 4 for additional information.

By signing this form, I understand the following: (1) if the entity authorized to receive my health information is not a health plan, health care provider or other covered entity as described by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, the released information may no longer be protected by federal privacy laws, rules and regulations; (2) the information disclosed will only include mental health, alcohol and substance abuse, HIV-related information, sexually transmitted disease, pregnancy and reproductive and/or genetic testing information if I specifically direct Company to release that information; (3) I am not required to sign this form, but if I do not sign this form, it will not be considered valid, it will be returned to me and no information will be released by Company; (4) I may revoke this authorization at any time by notifying Company in writing; (5) if I do revoke this authorization, my revocation will have no effect on any actions Company took according to this authorization before Company received my revocation; and (6) it is my choice whether I sign this form and signing or not signing this authorization will not affect any payment, enrollment, or eligibility for benefit decisions made by Company.

- ☐ By checking this box, this form replaces any HIPAA authorization forms previously sent to Company.

I sign this authorization under penalty of perjury and attest that the information contained in this authorization is true and correct and may be relied upon by Company.

\_\_\_\_\_  
**Signature of Member or Personal Representative**

Date: \_\_\_\_\_

## Sensitive Information

- **Alcohol and Substance Abuse Information**

By initialing the appropriate box on this form, alcohol and substance abuse information can be provided to the individuals listed by you on this form. If information is disclosed from alcohol or substance abuse records protected by federal confidentiality rules (42 CFR Part 2), these rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by these rules.

- **HIV-Related Information**

By initialing the appropriate box on this form, HIV-related information can be provided to the individuals listed by you on this form. HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

For example, under New York state law, HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; authorized agencies involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood; special court order; attorney assigned to represent a minor or by an executor or administrator of an estate (Public Health Law §2782). Under state law, anyone who illegally discloses HIV-related information may be punished by a fine of up to \$5,000 and a jail term of up to one year. However, some re-disclosures of medical and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

- **Pregnancy and Reproductive Information**

By initialing the appropriate box on this form, information relating to pregnancy and reproductive health can be provided to the individuals listed by you on this form. Information regarding pregnancy and reproductive health cannot be disclosed, even to a parent or guardian of a minor patient, without the specific authorization of the patient (Public Health Law §17).

- **Mental Health Information**

By initialing the appropriate box on this form, mental health information can be provided to the individuals listed by you on this form. Mental health information, including a patient's clinical records and information can be released, with your consent or the consent of someone authorized to act on your behalf, to those authorized agencies listed by you on this form who have a demonstrable need for such information provided such disclosure will not reasonably be expected to be detrimental to you or others (Mental Hygiene §33.13).

- **Sexually Transmitted Diseases**

By initialing the appropriate box on this form, information regarding sexually transmitted disease can be provided to the individuals listed by you on this form. Parents may access most of their child's medical records until the child turns 18, with the exception of information relating to the diagnosis and treatment of sexually transmitted disease (Public Health Law §17). Such information cannot be released to any party, including the child's parent or guardian, without the child's specific authorization.

- **Genetic Testing**

By initialing the appropriate box on this form, genetic testing information can be provided to the individuals listed by you on this form. Genetic testing information includes any information relating to laboratory tests of human DNA, chromosomes, genes or gene products to diagnose a predisposition to a genetic disease of disability in the individual or offspring (Civil Rights Law §79-l). Genetic testing information shall not be released without your specific consent with the exception of information released to a health insurer or health maintenance organization for the purpose of claims administration.

## **Instructions for Completion of Authorization to Disclose Protected Health Information (PHI)**

**Section A:** Enter your name, date of birth, and your member ID number including your suffix

**Section B:** List the name, relationship, and telephone number for the individuals and/or entities that you are authorizing to view or receive your health information.

**Section C:** Choose either Box C-1 **OR** box C-2 **AND** initial C-3 if applicable.

- **Box C-1:** Select this box to permit all of your health information to be disclosed. Please note, checking this box alone does NOT include the sensitive conditions listed in C-3, which you must separately initial in C-3.
- **Box C-2:** Select this box to limit the health information that you wish to be disclosed. You should write in the specific information you are authorizing to be disclosed and be as detailed as possible. Please note, checking this box alone does NOT include the sensitive conditions listed in C-3, which you must separately initial in C-3 or manually write in here.
- **Box C-3:** If you wish for any of these sensitive conditions to be disclosed, you must initial them individually here.

**Section D:** You may leave this section blank to default to the purpose and time period rules as indicated on the form, or you may specify a different purpose and/or time period.

- **Purpose:** The circumstances in which you are authorizing the information to be disclosed. For instance, you may choose to list a narrow purpose such as litigation or claim payment resolution. If left blank, your representatives may obtain your information upon their request.
- **Time Period:** The scope of the information to be released. For instance, you may choose to list a specific time frame such as 1/01/2021-12/31/2021. If left blank, your representatives may obtain your information from the start date of your plan coverage.

**Section E:** This form will expire automatically upon the events noted on the form, but you may specify additional dates or events that would trigger the form to expire, such as upon your death or listing a specific date.

**Section F:** If you are a personal representative that is acting on behalf of a member in signing this authorization, please check which authority you hold and include a copy of the relevant document(s) as proof of your legal representation and authority. Please list your name and telephone number as well as relationship to the member.

**Section G:** Please sign and date the form in this section, whether you are filling it out for yourself or on behalf of the member. As a reminder, if you are signing on behalf of the member, please include a copy of the relevant document(s) as proof of your legal representation and authority. If you wish this form to replace previous HIPAA Authorization forms on file with Company, please check the box in this section.