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 permitted to use or disclose your Protected Health Information (PHI) for payment, treatment, health care operations, and as required by law. For purposes other than treatment, payment or health care operations, your written authorization is required before sharing your PHI. This includes sharing your information with your spouse, relatives, employer, etc. This form allows you to authorize the Company to use or disclose your PHI to those individuals you specify in this form.

Please read before completing this form

- Incomplete authorizations will be considered invalid and will not be accepted. Incomplete authorizations will be returned.
- Completion of this authorization form is voluntary. You may refuse to sign this form, but the 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.
- Finally, you may revoke this authorization in writing at any time by sending a letter or, calling Nova's Customer Service Department using the number listed on your ID card. Your revocation notice will not apply to actions taken by the requesting person/entity prior to the date we receive your written request to revoke authorization.

Return your completed and signed authorization to:

Nova Healthcare Administrators, Inc.
P.O. Box 408
Buffalo, NY 14231
- or -
Fax: (716) 250-7193

If you need assistance completing this form, please contact our Customer Service Department using the number listed on your Identification Card.

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Authorization to Disclose Protected Health Information (PHI)

Under Federal and State privacy laws, I authorize: (please check)

- ❑ Nova Healthcare Administrators, Inc. and Independent Health
- ❑ Pharmacy Benefit Dimensions

to use or disclose my Protected Health Information (PHI) to the Individual(s)/Entity listed below.

Section A: Member/Participant Information Complete all information requested in this section for the member whose information will be released.		
Name: (Last, First, Middle Initial, Title [Sr., Jr., III.])	**Date of Birth:** / /	**Telephone Number:** ( )
Address:	**Group #:** (as shown on the member's ID card)	
City, State, Zip:	**Member ID #:** (as shown on the member's ID card) ☐☐☐☐☐☐☐☐☐ - ☐☐	

Section B: Authorized Individuals Please list the individuals and/or organizations that you are authorizing to view or receive your PHI. Include each individual's address and telephone number incase they need to be contacted in an emergency. If more space is needed to list who you are allowing to view or receive your PHI, attach an additional page.		
1.	**Name/Organization:**	**Relationship:**
	Address:	**Telephone Number:** ( )
2.	**Name/Organization:**	**Relationship:**
	Address:	**Telephone Number:** ( )

Section C: Description of Information that can be Released (Please check/initial all that apply)

If more space is needed to describe the PHI, attach an additional page. Please note: a special authorization form is required for disclosing confidential HIV-related Information. To obtain a copy of this form please visit www.novahealthcare.com then under "Members", click on "Frequently Used Forms" or call our Customer Service Department at the number listed on your ID card.

- ☐ Pre-Cert / Referral Information
- ☐ Enrollment / Benefits
- ☐ Disease Management
- ☐ Case Management Information
- ☐ Payment Information
- ☐ Pharmacy Information
- ☐ Claims Information (Medical and Dental)
- ☐ Health Management
- ☐ Demographic Information
- ☐ Reimbursement Account (FSA/HRA/Parking & Transit) Information
- ☐ **All of the above** (Does not include below)

I understand that **my specific authorization** is needed to release my information pertaining to the items listed below. By initialing, I authorize release of the following information pertinent to my case:

Pregnancy/Reproductive	**Psychotherapy/Mental Health**	**Alcohol/Substance Abuse**
_______ (Initials)	_______ (Initials)	_______ (Initials)

Section D: Purpose and Time Period
Unless noted below, the authorized individuals in Section B can obtain your health information upon their request and from the start date of your plan coverage through your employer.

☐ Purpose: ____

☐ Time Period: Only release health information concerning dates of service from (*insert date*) ____________ to (*insert date*) ____________

Section E: Scope of Authorization (Please check all that apply, This section must be completed)

☐ The individual(s) in Section B may discuss orally my PHI with Company.

☐ The individual(s) in Section B may inspect and/or obtain copies of my PHI from Company.

Section F: Expiration
Unless noted below, this authorization is valid until Company receives a letter canceling this authorization.

This authorization will expire:

☐ 1 year from the date of my signature

☐ 3 years from the date of my signature

☐ 5 years from the date of my signature

☐ On the following date (*insert date*): _____________

☐ On the following event: *(please specify)* ____

Section G: 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 - or - □ Certificate of Guardianship issued by a Court of appropriate jurisdiction.

If the member is deceased, please submit a copy of one of the following:
□ Administrator's or Executor's Certificate
□ Surviving Spouse Affidavit accompanied by a death certificate

Name: (Last, First, Middle Initial, Title [Sr., Jr., III.])	**Relationship:**
Address:	**Telephone Number:** ( )

Section H: Signature/Date
Please read the following carefully before you sign.

By signing this form, I understand the following: (1) if the entity authorized to receive my PHI 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/AIDS, sexually transmitted disease, abortion and/or genetic testing information if I specifically direct Nova 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.

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.

____ **Date:** _________________________

Signature of Member or Personal Representative