



APWU Health Plan Authorization for Release of Protected Health Information

You may authorize APWU Health Plan in writing to share your protected health information (PHI) with a third party (such as an employer, lawyer or unrelated party). By completing and signing this authorization, you allow another person or organization, designated by you, to have access to your health information as specified by you. This authorization will become effective once it has been entered into our systems, typically within 15 calendar days of receipt.

Please print neatly to ensure accurate processing and to avoid delays in service.

1. Member Information:

Member's ID #: _____

First Name: _____ MI: _____

Last Name: _____ Date of Birth: ____ / ____ / ____

Member's Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ____ - ____ - ____ Work Phone: ____ - ____ - ____

Policy Holder's Name: _____

Policy Holder's ID#: _____

2. At my request, I authorize my protected health information to be disclosed to:

1. First Name: _____ MI: _____ Last Name: _____

Company Name: _____

2. First Name: _____ MI: _____ Last Name: _____

Company Name: _____

3. First Name: _____ MI: _____ Last Name: _____

Company Name: _____

3. I authorize the following disclosures of my protected health information to the person/organization listed above.

Check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> ALL of My Information | <input type="checkbox"/> Claims and Explanation of Benefits (EOB) Information |
| <input type="checkbox"/> Enrollment and Benefits Information | <input type="checkbox"/> Premium Payment Information |
| <input type="checkbox"/> Any Documents Related to an Appeal | <input type="checkbox"/> Mental Health and Substance Abuse Information |

To further limit the information being shared, please be as specific as possible when selecting the options below:

- All services for a specific date (provide dates of service):
From: _____ To: _____

- All services from a specific health care provider (list provider's name):

- Other (please list specific PHI): _____

The information may be released for the following reason(s)*

* You may enter 'at my request'.

4. Expiration:

I would like this authorization to expire

- on ___ / ___ / ___ (Check this option if you want the authorization to expire in less than one year)
- after a specific event has occurred (e.g. after knee surgery or at end of pregnancy):

This authorization will expire one year from date of signature unless you select one of the options above.

5. Right to Revoke (Cancel):

I understand that I may revoke this authorization in writing at any time by sending a letter to the APWU Health Plan. Revoking this authorization will not affect any action that the APWU Health Plan took prior to receiving the written notice of revocation. The revocation should be sent to the APWUHP, Privacy Specialist, 799 Cromwell Park Drive, Suites K-Z, Glen Burnie, MD 21061.

Please refer to the Notice of Privacy Practices, available at www.APWUHP.com, for information pertaining to your opportunity to revoke an authorization, as well as the exceptions to this right. Also in the Notice of Privacy Practices is an explanation of all other available rights under the Privacy Rule.

6. Signature:

I, _____, hereby authorize the use and/or disclosure of my protected health information as described above.

I understand that:

1. this authorization is voluntary and being made at my request;
2. the released information may no longer be protected by federal privacy regulations once it has been released to the person/organization listed herein;
3. this authorization will not be used for medical underwriting; therefore, my treatment, payment, enrollment or eligibility for benefits will not be conditioned on my signing this authorization.

I have had the full opportunity to read and consider the contents of this authorization, and I confirm that the information is consistent with my direction to the Health Plan. I understand that by signing this form, I am giving my authorization to my Health Plan to use and/or disclose the protected health information specified in the contents of this authorization to the person and/or organization named.

Signature: _____ **Date:** _____

If the person signing this form is not the member whose information is being authorized for release**, please provide your full name and check the box that best describes your relationship to the member.

Print Your Full Name

- Personal Representative Power of Attorney Legal Guardian
 Other:

**** The proper documentation must be on file before this authorization can be processed.**

7. Please mail this authorization to:

APWU Health Plan
Privacy Specialist
799 Cromwell Park Drive
Glen Burnie, MD 21061
1-800-222-2798

**Please keep a copy of this authorization for your records.
We will provide you with a signed copy of this authorization at your request.**