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 to have access to your health information. 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. Requestor Information:

Requestor ID #: _____

First Name: _____ MI: _____

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

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____

E-mail Address: _____

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

First Name: _____ MI: _____ Last Name: _____

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____

E-Mail Address: _____

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

Check all that apply:

☐ ALL of my Information, Including Mental Health and Substance Abuse Information

☐ Enrollment and Benefits Information ☐ Premium Payment Information

☐ Any Documents Related to an Appeal ☐ Mental Health and Substance Abuse Information

☐ Claims and Explanation of Benefits (EOB) 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): _____

_____

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 APWU Health Plan, Privacy/Security 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 law 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 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 **Phone Number**

☐ Personal Representative ☐ Power of Attorney ☐ Legal Guardian

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

7. Please mail this authorization to:

APWU Health Plan
HIPAA Privacy/Security Specialist
799 Cromwell Park Drive; Suites K-Z
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.

Any mental health or substance abuse information disclosed by APWU Health Plan may be protected by federal and/or state laws. If these records are protected, Federal Regulation (42 CFR Part 2) prohibits the recipient of the information from further disclosing the information unless the subject of the information has given his/her written consent, or as otherwise permitted by 42 CFR Part 2. A general authorization for release of protected health information or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information for the intent of criminal investigation or prosecution of any alcohol or drug abuse patient.