

Instructions to Complete the AUTHORIZATION TO RELEASE HEALTH INFORMATION

Section 1 – Fill in the *Name, CDPHP Member ID# and DOB* of the individual whose information is subject to the release authorization. This section may also be used to identify a minor for whom you are a parent or legal guardian.

Section 2 – Select the appropriate box indicating the information that is being authorized to share.

There are three options:

*The first option authorizes CDPHP to share all of your health information. **Note: This includes potentially sensitive information related to HIV/AIDS, Mental Health, Substance and/or Alcohol Abuse, Genetic Testing, Family Planning, including Abortion and Sexually Transmitted Diseases.***

*The second option authorizes CDPHP to share all of your health information **except** the information specifically excluded by you.*

*The third option authorizes CDPHP to share **only** the information specified by you.*

Section 3 – Fill in the *name(s) and address(s)* of the individual(s) or organization(s) to whom CDPHP may disclose your information. CDPHP utilizes the address information provided by you in this section to verify with the designated individual upon contact from the designated individual.

Section 4 – This section must be completed in order for the authorization to be considered valid. If you do not wish to specify a reason for the release of information, please write in “*at the request of the individual*”.

Section 5 – Select the time period for which this authorization will be in effect.

There are two options:

*The first time period option, **Duration of Enrollment**, should be selected to maintain authorization while you are actively enrolled with CDPHP coverage.*

The second time period option provides you with the flexibility to designate a date specific release. For this option you must complete both the “From” and “to” with the appropriate date span.

Section 6 – Please be sure to read and understand your rights related to this authorization as detailed on the second page. Then, *sign and date the form and print your name* underneath your signature. In the event you are authorizing CDPHP to share a minor’s health information for whom you are the parent or legal guardian, please also indicate your *relationship* to the individual.



Authorization to Release Health Information

Name _____ ID # _____ DOB ____ / ____ / _____

By completing this form you are authorizing Capital District Physicians' Health Plan, Inc. and its affiliates (hereafter referred to as "CDPHP®") to disclose your information to the individual or entity identified by you below.

I authorize the use or disclosure of the health care information as described below. *Check the box below that applies:*

- All information available in my CDPHP records. This includes information relating to:
 - Alcohol and/or Substance Abuse*
 - Mental Health Conditions
 - HIV/AIDS**
 - Genetic Diseases or Tests
 - Family Planning, including Abortion
 - Sexually Transmitted Diseases
- All information available in my CDPHP records except _____

- Other (You must describe the specific information to be released in the space below.) _____

This information may be disclosed to the following individuals or organizations:

Name: _____

Street Address: _____

City, State, Zip: _____

Name: _____

Street Address: _____

City, State, Zip: _____

Please indicate the purpose(s) for this release of information.

If you do not wish to state a specific purpose, please state "at the request of the individual": _____

Check only one box for the period of time the authorization is to be in effect:

- duration of enrollment with CDPHP *or* from ____ / ____ / _____ to ____ / ____ / _____

In the case of minor dependent, this authorization will terminate upon the first of the following to occur: written revocation by the under-signed, the expiration date of the time period noted above or when the named minor dependent reaches the age of eighteen (18) years.

Sign and Date This Form

Signature

Date (DD/MM/YYYY)

Print Name
09-0874

Relationship to Member

Your Rights Related to The Disclosure Of Your Information

- This authorization is voluntary and you may refuse to sign.
- Your refusal to sign will not affect CDPHP payment for services or your eligibility for CDPHP benefits.
- The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal privacy rules of the Health Insurance Portability and Accountability Act of 1996.
- You have the right to revoke this authorization at any time except to the extent that CDPHP and/or other professionals or entities have already acted in reliance on it.

***Prohibition on Redisclosure of Alcohol and Substance Abuse Related Information**

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.

****Your Rights Related to the Release of Confidential HIV/AIDS Information**

Confidential 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. By checking the first box and signing this form, medical information and/or HIV-related information can be given to the people listed by you on this form, for the reason(s) listed.

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; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. 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. The law protects you from HIV related discrimination in housing, employment, health care and other services. For more information call the New York State Division of Human Rights Office of AIDS Discrimination Issues at **1-800-523-2437** or (212) 480-2522 or the New York City Commission on Human Rights at **(212) 306-7500**. These agencies are responsible for protecting your rights.

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.