

COLLEGE OF THE SISKIYOU'S HEALTH PLAN
AUTHORIZATION REQUEST TO USE OR DISCLOSE

Purpose: This form is used to request an individual's *unconditioned* authorization for the Health Plan to use or disclose protected health information for the purpose stated.

SECTION A: Psychotherapy Notes.

Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information.

SECTION B: The Individual from whom this authorization is being requested.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Enrollee Number: _____

SECTION C: Please read and complete the following statements carefully.

No Conditions: This authorization is voluntary. The Health Plan will not condition our payment activities in connection with your claims, your enrollment in the Health Plan or your eligibility for benefits on you giving this authorization.

Purpose of this Authorization: By signing this form, you will authorize the Health Plan to use and/or disclose your protected health information for the following purposes: (i.e. to resolve unpaid claims)

Effect of Granting this Authorization: The protected health information described below may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

Protected Health Information to Be Used and/or Disclosed: The specific protected health information (including date[s], if applicable) we are asking you to authorize us to use and/or disclose for the purposes stated above is: (i.e. provider name, date of service, etc.)

Inspection and Copy of the Protected Health Information: You have the right to inspect and/or copy the protected health information described above.

Entities Authorized to Use or Disclose: The persons and/or organizations (or the classes of persons and/or organizations), including the Health Plan, who you are authorizing to make use of and/or to disclose the protected health information described above are:

- Keenan TPA
- Blue Cross
- Delta Dental
- Medical Eye Services
- Provider
- Other _____

Entities Authorized to Receive and Use: The persons and/or organizations (or the classes of persons and/or organizations) to whom you are authorizing the Health Plan to disclose and/or let use the protected health information described above are:

- Keenan TPA
- Kelly Groppi
- Other _____

SECTION D: Remuneration (check one).

- The Health Plan will *not* receive direct or indirect remuneration from a third party as a result of the use and/or disclosure of the protected health information requested by this authorization.
- The Health Plan *will* receive direct or indirect remuneration from a third party as a result of the use and/or disclosure of the protected health information requested by this authorization.

SECTION E: Expiration and Revocation.

Expiration: This authorization will expire (complete one):

- On ____/____/_____
- On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized): (i.e. when claim is resolved)

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

SIGNATURE—YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

I have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that the Health Plan may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form for the purposes stated in this form.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described in this form are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.