HealthAdvocate℠

Mail or Fax this form to:

3043 Walton Road
Plymouth Meeting, PA 19462

Fax: 610.941.4200

Authorization for Use and Disclosure of Protected Health Information

Description of PHI to be Released to Health Advocate:

I hereby authorize my health plan(s), my healthcare providers and their applicable business associates to disclose the following Protected Health Information ("PHI") pertaining to me: enrollment, claims, payment and managed care information to Health Advocate, Inc. for the purpose of assisting me in my effort to obtain healthcare services and/or approval or payment for healthcare services.

My authorization includes the release of the following, please check those you wish to include, if any:

- ☐ Diagnosis and/or treatment for alcoholism and/or drug abuse or dependency
- ☐ Diagnosis and/or treatment regarding mental health issues
- ☐ HIV antibody test results and/or diagnosis and treatment
- ☐ Genetic test results and/or related treatment

Identification of Person Authorizing Release: (Please complete all items.)

Name of Member/Participant: _____ (Last) _____ (First) _____ (MI)

SSN (Optional)**:** _____ **Date of Birth:** _____ **Relationship to Subscriber:** _____

Address: _____ (Street (Apt #)) _____ (City) _____ (State) _____ (Zip)

Subscriber Name: _____

Subscriber's Sponsor Name (e.g., Employer, Health & Welfare Fund): _____

Health Insurance Carrier 1: _____

Coverage Type:

☐ **HMO** ☐ **POS** ☐ **PPO** ☐ **Indemnity** ☐ **Medicare**

ID#: _____

Health Insurance Carrier 2: _____

Coverage Type:

☐ **HMO** ☐ **POS** ☐ **PPO** ☐ **Indemnity** ☐ **Medicare**

ID#: _____

Unless otherwise revoked, this authorization will commence on the date indicated next to the signature line and will expire on the following date, event or circumstance: _____. If I fail to specify, this authorization will expire in twelve months from the date of my signature.

- I understand that information used or disclosed based on this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.
- I understand that I may revoke this authorization at any time by giving written notice of my revocation to Health Advocate's Privacy Officer at the above address. I understand that revocation of this authorization will not affect any action Health Advocate or other parties took in reliance on this authorization before it received my written notice of revocation.
- I understand that Health Advocate provides administrative and informational services only and does not provide health insurance or medical services nor does it recommend treatment. Consequently, independent healthcare practitioners, who are not employees or agents of Health Advocate, will provide all my medical services.

You are not required to authorize Health Advocate to have access to your "PHI" and the provision of treatment, payment, enrollment or eligibility for benefits does not depend on whether you sign this authorization. You should keep a signed copy of this authorization for your records, however, a copy of this signed authorization will be provided upon your request.

Signature: _____ **Date:** _____
(Member/Patient unless a Minor; or legal guardian of member/patient if unable to sign)

Name of Designated Representative/Legal Guardian: _____
(Authorized to act on my behalf)

Relationship of Personal Representative to Member/Patient i.e., spouse, parent, guardian, etc.: _____

HealthAdvocate℠

Notice of Privacy Policy and Practices

This notice describes how protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Purpose

Health Advocate respects the privacy of protected information and understands the importance of keeping this information confidential and secure. This notice describes Health Advocate's policies and practices for collecting, handling and protecting the protected health information of our members. From time to time, it may be necessary to revise our privacy policy and practices. Should such a change be required, we will notify you in writing in advance of the change.

Protected Health Information

As a Health Advocate member, your healthcare information, including, but not limited to, your name, address, social security number, member identification number, medical records, billing records, claims information, medical conditions, prescribed medications, and precertification information ("Protected Health Information"), needs to be collected, maintained and made available to Health Advocate employees and strategic partners so that Health Advocate can administer its programs on your behalf.

You have the right to: (i) request certain restrictions on the use of your Protected Health Information; (ii) receive an accounting of disclosures of use of your Protected Health Information; (iii) amend your Protected Health Information; (iv) complain to Health Advocate's designated privacy officer at 610.397.6965, or the Secretary of Health and Human Services if you believe your privacy rights have been violated; and/or (v) revoke your authorization to Health Advocate to use and disclose your Protected Health Information.

Disclosure

- We will use and disclose Protected Health Information as necessary to administer Health Advocate's programs.
- We may disclose Protected Health Information with contracted service providers.
- We may disclose Protected Health Information as permitted by law with our attorneys, accountants and auditors, your authorized representatives, if any, healthcare providers, third party administrators, insurance companies, or insurance agents and brokers.
- We may disclose your Protected Health Information to government agencies or accrediting organizations that monitor our compliance with applicable laws and standards.
- We may disclose your Protected Health Information under order of a court of law in connection with a legal proceeding or pursuant to a subpoena or summons by government agencies that investigate fraud or other violations of law.
- We will not disclose Protected Health Information to any other third parties without a member's request or authorization.