Affinity Health Plan

Authorization to Use or Disclose Member Protected Health Information

This form is used to authorize the release, use or disclosure of the Confidential Protected Health Information of an Affinity member, as required by state and federal law (including HIPAA). It allows Affinity to release the information to specified individuals or entities, for specific purposes, for a specific period of time. Note that incomplete forms may not be processed and additional information may be required.

1. Member/ Insured Information: (please complete all fields)

Member's Name (Last, First): ______________________________ If minor, Guardian's name: ______________________________

Member ID#: ______________________ Date of Birth: ______________ Social Security # : ______________________

Street Address: ______________________________ Phone #: ______________________

2. Recipient Information: *Provide information about the individual or entity being authorized to receive the member's health information*

Name : ____

Address: ______________________________ Phone #: ______________ Fax #: ______________

3. Purpose of this Authorization: *The reason for this disclosure request*

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4. Protected Member Information to be released or disclosed: *check all that apply*

☐ ALL INFORMATION: includes clinical (diagnosis, treatment), claims, billing, and coverage

☐ LIMITED INFORMATION: (specify)______________________________

The following information requires special authorization to disclose. Check and initial your selection(s).

☐ Mental/Behavioral Health ______ ☐ Substance Use ______ ☐ HIV/AIDS ______

☐ Reproductive Health/ Sexually Transmitted Disease _______ ☐ Genetic Testing _____

5. Length of Authorization: Indicate when this authorization should end (expire).

☐ This authorization should end on the following date: ______________________________

☐ This authorization should end upon the following event: ______________________________

If no ending date or event is specified, this authorization will expire 24 months from the date signed. The authorization can be revoked (cancelled) in writing at any time.

6. Signature: The member or his/her personal representative (a person legally authorized to act on the member's behalf) must sign this authorization for it to be valid. A parent or guardian must sign for a dependent (unemancipated) child under age 18.

By signing this authorization form, I am attesting that:

- I have read and understood the terms of this authorization, and have had the opportunity to ask questions about how information will be used and disclosed by Affinity Health Plan to the recipient that I have named.
- This authorization is completely voluntary, that I can refuse to sign it, and that continued treatment, coverage, enrollment, eligibility and/or other benefits cannot be conditioned upon my willingness to sign this authorization.
- I understand that this authorization can be revoked (ended) by me, in writing, at any time and for any reason, and that revocation will not affect any disclosures made before my written revocation notice is received by Affinity Health Plan.
- Information disclosed may be re-disclosed by the recipient, in which case it may no longer be protected by privacy laws.
- I am the member or have valid legal authority to act on behalf of the member named in this authorization.
- The information provided on this form is true, accurate and complete, to the best of my knowledge and ability.
- I am entitled to a copy of this authorization.

Member's Signature:____ Date: _____________

Personal Representative's Signature: **Print Name**:

____________________________________ _____________________________ Date: ______________

A Personal Representative signing this form must specify his or her relationship to Member below:

☐ Parent ☐ Legal Guardian* ☐ Power of Attorney* ☐ Other* ___________________

** Documentation of your legal authority to act on the member's behalf is required.*

Mail the completed form to:

Affinity Health Plan
Attn: Customer Service Department
Metro Center Atrium
1776 Eastchester Road, Bronx, NY 10461
Phone: (866) 247-5678; Fax: (718) 794-7804

Keep a copy of this request for your records.