MEMBER AUTHORIZATION TO DISCLOSE
PROTECTED HEALTH INFORMATION

Member Name _____ Date of Birth _____

Street Address _____ Member ID # _____

City, State, ZIP _____

Maiden/Other Names _____ Phone Number _____

I hereby authorize my health plan to disclose my protected health information to:
Please fill out the name of person or organization (authorized person) and their relationship to you (for each person/organization you're disclosing your information to).
Hally® MyChart Access: If you choose Yes to Hally MyChart Access, see access outlined in Hally.

Name		Relationship	
Address		Phone #	
City, State, ZIP		Alt Phone #	
Hally MyChart Access (If Yes, include email and DOB below.)		Yes ☐ No ☐ (*check one*)	
Email Address		Date of Birth	

Name		Relationship	
Address		Phone #	
City, State, ZIP		Alt Phone #	
Hally MyChart Access (If Yes, include email and DOB below.)		Yes ☐ No ☐ (*check one*)	
Email		Date of Birth	

Name		Relationship	
Address		Phone #	
City, State, ZIP		Alt Phone #	
Hally MyChart Access (If Yes, include email and DOB below.)		Yes ☐ No ☐ (*check one*)	
Email		Date of Birth	

All protected health information may be disclosed to the authorized persons stated on Page 1, unless I otherwise specify below.

Authorized person(s) is allowed to change my primary care provider. Yes ☐ No ☐ (*check one*)

The purpose of this disclosure is to comply with your request. If there is another purpose for the disclosure, please specify below.

_____

_____

Authorized person(s) is allowed to access my protected health information, listed below (*check one per box*).

☐ Yes ☐ No	• Communicable disease and infection information (which includes venereal disease, "VD," tuberculosis, "TB," hepatitis B, human immunodeficiency virus "HIV," acquired immunodeficiency syndrome, "AIDS," AIDS related complex, "ARC," and specify other if known). _____
☐ Yes ☐ No	• Alcohol and/or drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations, Part 2. (See **"Important Notice"** on page 3.)
☐ Yes ☐ No	• Mental health treatment records, psychological services and social services information, including communications made by me to a social worker or mental health professional.

I have read and I understand and acknowledge the following statements about my rights:

- I may revoke this authorization at any time prior to the expiration date by notifying my health plan in writing. However, the revocation will not have any effect on actions taken before the revocation was received.
- If the person or organization to whom this information is disclosed is not a covered entity under the federal privacy rules, the information may no longer be protected by the federal privacy rules after such disclosure is made.
- Treatment, payment, eligibility or enrollment will not be conditioned on obtaining this authorization except as specifically authorized by law.

This authorization expires (*check one*):

☐ One Year
☐ Life of the Policy
☐ Upon the following specific date, event or condition (*please add information below*):

_____

I accept these terms and authorize disclosure of my protected health information as stated on this form (*dependents age 18 and over must sign below*):

_____ _____

Member Signature Date

_____

Printed Name of Member

If a legal representative signs on behalf of the member, my health plan must have a copy of the legal document declaring representation on file (e.g., Power of Attorney, Legal Guardian, Executor of Estate). If a legal document declaring representation has not been submitted, please submit a copy with this form.

Legally Authorized Representative's Signature

Date

Printed Name of Legally Authorized Representative

Please sign and return this completed form to:

Member Authorization Processing Center
Attn: Privacy Officer
3310 Fields South Drive
Champaign, IL 61822

Or fax it to: (217) 902-9794

IMPORTANT NOTICE: ANY INFORMATION DISCLOSED IS PROTECTED BY FEDERAL PROTECTION RULES (42 CFR. CH. I, PART 2) AND STATE MENTAL HEALTH PROTECTION LAWS AND IS PROHIBITED FROM FURTHER DISCLOSURE UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN AUTHORIZATION OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHORIZATION FOR RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. FEDERAL RULES RESTRICT USE OF THE INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY MEMBER RECEIVING TREATMENT FOR ALCOHOL OR DRUG ABUSE.

TIPS ON COMPLETING THE AUTHORIZATION FORM

Where it states, "I hereby authorize my health plan to disclose my protected health information to," please list the name of the person(s) or organization(s) who you are allowing your health plan to disclose information to, their relationship to you, and their address and telephone number if different from yours. The individual(s) or organization(s) you list on the form is referred to as the "Authorized Person(s)."

Choose either "Yes" or "No" for Hally® MyChart access. If neither box is checked OR the email address and date of birth for the authorized person are not provided, the authorized person will not be given online access to your account. The date of birth is required for verification and the email is required to send the authorized person an email that they have been added to your account.

The form states that ALL protected health information will be disclosed to the authorized person(s) unless you specify otherwise. You do not have to complete this section unless there is only specific information that you would like your health plan to disclose to the authorized person(s).

Please indicate whether the authorized person(s) is allowed to change your primary care provider on your behalf, by checking the appropriate box. If neither box is checked, the authorized person(s) will not be allowed to change the primary care provider.

The form states that the purpose of the disclosure is to comply with your request. If there is another purpose for the disclosure, please specify this purpose on the form; otherwise, you do not have to complete this section.

In the boxed section on the second page, check the "Yes" or "No" box for disclosure of potentially sensitive protected health information to the authorized person(s). If neither box is checked, we will assume we are not to release any of your sensitive protected health information to the authorized person(s).

The authorization form states your rights. Please read these rights carefully.

Where it states "This authorization expires," please check the appropriate box. If you do not check a box, the authorization will term after one (1) year.

If a legal representative signs on your behalf, a legal document (i.e., Power of Attorney, Legal Guardian, Executor of Estate) must be on file or submitted with the Authorization Form. The Power of Attorney form must be witnessed and notarized. The Legal Guardian and Executor of Estate documents must either bear a court seal or Filed Date.

When you have all the appropriate sections of the form completed, please mail it to Member Authorization Processing Center, Attn: Privacy Officer, 3310 Fields South Drive, Champaign, IL 61822, or fax to the Attn: Privacy Officer at (217) 902-9794.

If you have any questions or additional concerns, you may contact a member of our Customer Service department at the number listed on the back of your health plan ID card or TTY at 711 or (800) 526-0844 for those with hearing impairments. Representatives are available from 8 a.m. to 5 p.m. Monday through Friday.