Jefferson Health Plans

Authorization for the Use or Disclosure of Protected Health Information

Use this form to authorize Jefferson Health Plans CHIP to use or disclose your health information to another person or organization.

Instructions for Completing this Authorization Form

Part 1: Member information. This section should name the Jefferson Health Plans CHIP member whose health information will be shared with and/or disclosed to the authorized person/organization. Print the member's name, birth date, address on file, telephone number, and Member ID number.

Part 2: Person or company who will receive this information. This section should name the authorized person/organization who will be contacting Jefferson Health Plans CHIP to discuss the member's health information. A **separate form** must be completed for each person or organization. We suggest photocopying the blank form for multiple uses.

Part 3: Information that can be released. This section should indicate what health information Jefferson Health Plans CHIP may share with and/or disclose to the authorized person/organization.

Part 4: Purpose for the release or disclosure. This section tells us the reason you have asked for the release of your health information.

Part 5: Date your approval expires. The authorization requires a date be given or specific event for expiration of the authorization (e.g., 1/15/2024, January 2024, or a statement such as "when I am no longer a member"). If there is not a date or specific event provided, the form will expire in 6 months from when signed.

Part 6: Review and approval. The *member's* signature is required. If the member is incapable of signing, a personal or legal representative may sign on the member's behalf. Parents or guardians of minors will be confirmed using information from the state. A personal representative such as an executor or someone with a Power of Attorney may sign his or her name in the member's place. The legal documents proving the authority of the personal representative on behalf of the member **MUST** be attached or on file at Jefferson Health Plans CHIP; otherwise the personal representative's signature will be invalid and this form will **NOT** be processed.

Disclosure: Notice regarding Re-Disclosure and Prohibited Use of Substance Use Disorder Information
HIV/AIDS and other sexually transmitted diseases, behavioral health, genetic markers, and Substance use diagnosis, treatment, or referral for treatment from a federally assisted Part 2 program are protected by Federal confidentiality rules which prohibit any further disclosure of this information unless you obtain written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. These rules prohibit anyone from using or disclosing these records, or any testimony describing information contained in these records, in any civil, criminal, administrative, or legislative proceeding by any Federal, State, or local authority against the patient, unless authorized by the patient's written consent or as authorized by a court in accordance with Part 2. Once lawfully received with appropriate consent, HIPAA-regulated entities may redisclose SUD information in accordance with HIPAA, except where Part 2 provides additional protection (for example, certain counseling session notes).

Complete ALL sections. If information on this form is not complete Jefferson Health Plans CHIP will return the form and will not approve this request until it is completed in full.

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Contact Information

RETURN YOUR FORM(S) TO THE ADDRESS OR FAX NUMBER LISTED BELOW.

If you have any questions or need assistance in completing this form, call the Member Relations telephone number on the back of your identification card or write to:

Jefferson Health Plans CHIP
Privacy Services
1101 Market Street, Suite 3000
Philadelphia, PA 19107
or Fax: 267-515-6666

Please keep a copy of this Authorization and the instructions for your records

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All fields are required.

1. Person whose information is to be disclosed (the "member")	
Member Name:	**Date of Birth:**
Address:	**City/ZIP:**
Member ID #:	**Telephone:**

2. Who is authorized to receive the member's information (the recipient").	
Recipient's or Organization Name:	Relationship to Member:
Address:	Telephone:
	Fax:

3. What health information may Jefferson Health Plans CHIP release? (Check all that apply)

☐ **All** of my (member) protected health information.

☐ Benefit information only (copays, pharmacy, eligibility/coverage information)

☐ Coordination of care information only (such as care and control, social worker, or disease management information)

☐ Psychotherapy notes – ***If you check this box, you may not check any other boxes in this section.*** *An authorization for the release of psychotherapy notes may not be combined with an authorization for disclosure of any other type of information.*

☐ Special instructions: _____

***NOTE:** Federal and state law requires that you provide specific permission to release the information below even if you checked a box above. Indicate your permission for Jefferson Health Plans CHIP to release any of the following information by initialing all that apply.

Genetic information _____ (Initials) **HIV/AIDS** _____ (Initials)

Alcohol/substance abuse _____ (Initials) **Mental/behavioral health** _____ (Initials)

4. What is the purpose of the requested uses or disclosure of Information?

☐ To **discuss** my health information in person, writing, or by phone

☐ To **discuss and make changes** to my health information (such as Primary Care Physician changes)

☐ Other/special purpose: _____

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Authorization for the Use or Disclosure of Protected Health information
All fields are required.

5. Expiration and revocation

This Authorization **will expire** on __ / __ / ____ (month/day/year) **OR** upon the following event (e.g., "when I am no longer a member"). _____

6. Signature

By signing below, I understand that I am authorizing the use/release of my health information and:

A. My authorization is voluntary and not a condition of enrollment, eligibility, or claim payment.

B. If the authorized persons or organization listed above is not subject to federal or state health information privacy laws, they may further release my health information and it may no longer be protected by federal and state privacy laws.

C. I may revoke/cancel this Authorization at any time by sending written notice to Jefferson Health Plans CHIP or submitting the Revocation Form. However, I understand that any revocation/cancellation of this authorization will not affect any action taken by Jefferson Health Plans CHIP before it received my signed revocation.

MEMBER OR PERSONAL REPRESENTATIVE SIGNATURE

I have read and understand the above information:

Member or personal representative name: _____

Signature: _____

Date: _____

If you are a personal representative, state your relationship to the member: _____

Note that, if not already provided, we will require verification of the authority of a personal representative such as a copy of a health care, general or durable power of attorney before this request will be considered complete. If this request is made by a parent/guardian, complete the following: Member/participant is a minor _____ years of age. If you are making this request on behalf of a minor child, we may require additional information such as a court order or other documentation that shows custody or other legal document showing the authority of the legal representative to act on the member's behalf before this request is considered complete.

Pennsylvania's Children's Health Insurance Program
We Cover All Kids.

Jefferson Health Plans

Discrimination is Against the Law

Jefferson Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

Jefferson Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

Jefferson Health Plans provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Jefferson Health Plans provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Jefferson Health Plans at **1-888-888-1211 (TTY 1-877-454-8477).**

If you believe that Jefferson Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation, you can file a complaint with:

Jefferson Health Plans
Attn: Complaints, Grievances & Appeals Unit
1101 Market Street, Suite 3000
Philadelphia, PA 19107
Phone: 1-888-888-1211 (TTY 1-877-454-8477)
Fax: 1-215-991-4105

The Bureau of Equal Opportunity,
Room 223, Health and Welfare Building,
P.O. Box 2675,
Harrisburg, PA 17105-2675,
Phone: (717) 787-1127, TTY/PA Relay 711,
Fax: (717) 772-4366, or
Email: RA-PWBEOAO@pa.gov

You can file a complaint in person or by mail, fax, or email. If you need help filing a complaint, Jefferson Health Plans and the Bureau of Equal Opportunity are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone or email at:

U.S. Department of Health and Human Services,
200 Independence Avenue SW.,
Room 509F, HHH Building,
Washington, DC 20201,
1-800-368-1019, 800-537-7697 (TDD).
OCRMail@hhs.gov

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

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Notices of Availability

ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-888-888-1211 (TTY 1-877-454-8477) or speak to your provider.

Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-888-888-1211 (TTY 1-877-454-8477) o hable con su proveedor.

Chinese; Mandarin
注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-888-888-1211（文本电话：1-877-454-8477）或咨询您的服务提供商。

Nepali
सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि गि: शुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि नि: शुल्क उपलब्ध छन्। 1-888-888-1211 (TTY 1-877-454-8477) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

Russian
ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-888-888-1211 (TTY: 1-877-454-8477) или обратитесь к своему поставщику услуг.

Arabic
تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مبسطة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-888-888-1211 (1-877-454-8477) أو تحدث إلى مقدم الخدمة.

Haitian Creole
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-888-888-1211 (TTY: 1-877-454-8477) oswa pale avèk founisè w la.

Vietnamese
LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-888-888-1211 (Người khuyết tật: 1-877-454-8477) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Ukrainian
УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-888-888-1211 (TTY: 1-877-454-8477) або зверніться до свого постачальника.

Chinese; Cantonese
注意：如果您說中文, 我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務, 以無障礙格式提供資訊。請致電 1-888-888-1211 (TTY: 1-877-454-8477) 或與您的提供者討論。

Portuguese
ATENÇÃO: Se você fala português do Brasil, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-888-888-1211 (TTY: 1-877-454-8477) ou fale com seu provedor.

Bengali
মনোযোগ দি: দি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-888-888-1211 (TTY: 1-877-454-8477) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

French
ATTENTION: Si vous parlez Français, des services d’assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-888-888-1211 (TTY: 1-877-454-8477) ou parlez à votre fournisseur.

Cambodian
សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ *ភាសាខ្មែរ* សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃផងដែរ។ ហៅទូរសព្ទទៅ 1-888-888-1211 (TTY: 1-877-454-8477) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។

Korean
주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-888-888-1211 (TTY: 1-877-454-8477)번으로 전화하거나 서비스 제공업체에 문의하십시오.

Gujarati
ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-888-888-1211 (TTY: 1-877-454-8477) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.