

Authorization for Release of Protected Health Information



Passport Advantage HMO needs to share your information with health care providers to help you get medical care. You or your representative must read and initial both pages of this form.

SECTION A: Must be completed for all authorizations

By signing this form, I give Passport Advantage permission to:

1. Get my personal health information from my health care providers, and
2. Give my personal health information to my health care providers.

I understand that this information will only be used for the purpose of treatment, payment, AND health care operations.

I understand that Passport Advantage cannot use my information for any other reasons.

I understand that if my information is given to someone who is not a health plan or health care provider, it may no longer be protected by federal privacy laws.

I understand that I do not have to fill out this form to still be a member of Passport Advantage.

I do not want Passport Advantage to share my personal health information with the following health care provider(s):

Print Member Name: _____

SECTION B: Must be completed only if a health plan or a health care provider has requested the authorization

1. I understand Passport Advantage will only be using my personal health information (including physical health, mental health, substance abuse, HIV and AIDS status) for the purpose of treatment, payment, and health care operations.

I understand Passport Advantage will not use this authorization to get financial or any in-kind payment for using or disclosing the health information listed above.

2. I understand that I do not have to sign this form.

Initials X _____

I understand that I will still get my health care if I do not sign this form.

Initials X _____

Please continue to page 2

I understand that I may see and copy the information on this form if I ask for it.

Initials X _____

I understand that I will get a copy of this form from Passport Advantage after I sign it.

Initials X _____

SECTION C: Must be completed for all authorizations

1. I understand that my personal health information will be kept private after I leave Passport Advantage.

Initials X _____

2. I understand that I can destroy this agreement at any time.

If I no longer want Passport Advantage to use my information, I understand that I must write to Passport Advantage and tell them this.

I understand that Passport Advantage will continue to use my information until they get my letter.

Initials X _____

3. I understand that this form will be in effect as long as I am a Passport Advantage member.

Initials X _____

STOP!

Before you finish ... have you put your initials on each of the categories above?

Signature of Member or Legal Representative: _____

Date: _____

Printed Name of Member or Legal Representative: _____

Date: _____