Authorization for Disclosure of Private Health Information

I hereby authorize Simplicity Health Plans*, its agents, subsidiaries and/or its business associates to disclose the Private Health Information (PHI) indicated below to the persons or entities specified on this form.

Please Note: This form is not required for all releases of your PHI. For example, this form may not be required to release information to:

- A spouse of a Member/Participant, when both are covered by Employer Sponsored health plan managed by Simplicity Health Plans
- Parents of minors or other dependents
- Personal Representative on file with Simplicity Health Plans

We will disclose certain PHI about you to these persons upon their request if they successfully complete a caller verification process. Please print your responses on this form. All sections must be completed for this authorization to be valid.

VERIFICATION *(Please Fill in Form or Print Clearly)*

Identification of Member/Participant whose information will be disclosed:

(The following information is needed for verification. Please complete all applicable items)

Name of Member/Participant: _____ Date of Birth: _____/_____/_____

Member/Participant Address:

Street: _____ Apt#: _____

City: _____ State:_____ Zip:_____

Daytime Phone #: (_____) _____-_____ Evening Phone (_____) _____-_____

(Phone Number is required and necessary if we need to contact you to process your request)

Social Security #: _____-_____-_____

Member/Participant ID card # *(if applicable)*: _____

Group # on ID card: _____

Subscriber Name *(if different from Member/Participant)*: _____

Subscriber's Relationship to Member/Participant: _____

Subscriber's Employer Name: _____

Subscriber's Social Security # *(if different from Member/Participant)*: _____-_____-_____

If you have additional coverage with another employer plan managed by SIMPLICITY HEALTH PLANS, other than described above, please complete the following information:

Other Employer Name: _____

City: _____ State: _____ Zip: _____

Member/Participant ID card #: _____

Group or Account # on ID card: _____

Does this request apply to all coverage? Yes No

DESCRIPTION OF INFORMATION TO BE RELEASED

Please indicate what information you wish to release by checking one or more of the boxes below. If you wish to grant limited access (i.e., specific dates of service, specific case management issues, etc.), please specify in the space provided.

- ☐ Claims: _____
- ☐ Eligibility/Benefits: _____
- ☐ Medical Records: _____
- ☐ Case Management: _____
- ☐ Other: _____

My authorization includes the release of the following: ***(Please check if you wish to include)***

- ☐ Diagnosis and/or treatment for alcoholism and/or drug abuse or dependency
- ☐ Diagnosis and/or treatment of mental illness
- ☐ HIV antibody test results and/or AIDS diagnosis and treatment
- ☐ Genetic testing information

Oklahoma Residents *– The information authorized for release may include records concerning a communicable or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and HIV/AIDS. You may have additional protections under Section 1-502.2 of the Oklahoma Statutes if this type of information is to be released.*

Entity or Person Authorized to Receive Information

First Name: _____ Middle Initial_____ Last Name: _____

Company Name *(if applicable)*:_____

Address of Individual or Company authorized to receive the information:

Street: _____ Apt#: _____

City: _____ State:_____ Zip:_____

Virginia Residents *– A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with your original health records.*

PURPOSE OF THIS RELEASE OF INFORMATION

EXPIRATION OF AUTHORIZATION

This authorization expires on: _____/_____/_____*(date)*

Or, this authorization expires on: _____ *(event)*

If you state an event rather than a specific date, it will be necessary for you to submit a revocation form when the event occurs.

Note for Members/Participants in the following states:

If you live in ***Arizona, California, Georgia, Illinois, Massachusetts, Montana or Minnesota****, your authorization will be valid for no more than one year. Authorizations signed by* ***Virginia*** *residents will be valid for no more than two years. Members/Participants living in those states who seek to authorize disclosure of their personal information for a longer period will have to submit a new authorization at the time that this authorization expires.*

Please read the following notes. The next page MUST BE completed.

PLEASE NOTE

- Information disclosed based on this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.
- If the information on this form is not complete, Simplicity Health Plans will return the form to you, and this request will not be considered until Simplicity Health Plans receives complete information.
- If your Member/Participant ID or date of birth is changed, another form must be completed at that time.
- If either the Member/Participant or Group changes to a different type of health care benefits coverage provided by the Employer, another form must be completed at that time.
- You may change or revoke this request by sending a written request to Simplicity Health Plans, HIPAA Unit, at the address below.
- You can obtain a Change/Revoke form by calling Simplicity Health Plans Member Services at the number on your Simplicity Health Plans ID card.
- The provision of treatment, payment enrollment or eligibility for benefits does not depend on whether you sign this authorization.

I have read and understand the above information. My signature authorizes the disclosure of the information described.

I have read and understand the above information:

_____Date: _____/_____/_____
Signature of Member/Participant, Parent, Custodian, Guardian or Personal Representative

Relationship if signed by other than Member/Participant: _____

If this request is made by a Parent, Custodian or Guardian, please complete the following:

I hereby certify that the Member/Participant, _____, is a minor,_____ years of age.
I further certify that I am the parent, custodian and/or guardian *(hereinafter known as "the Legal Representative")* for the above named Minor Member/Particpant and that the following information is true and correct:

My Name is:
First Name: _____ Middle Initial: _____ Last Name: _____
My Permanent Residence is located at:
Street Address: _____ Apt #:_____
City: _____ State:_____ Zip:_____
My Social Security Numer is: _____-_____-_____

We recommend you keep a copy of your completed form for your records. A copy will be retained by Simplicity Health Plans and made available upon your request.

TO RETURN YOUR COMPLETED FORM

Fax to: 216-283-7931

Or Mail to:

Simplicity Health Plans
HIPPA Auth
20600 Chagrin Blvd. Suite 450
Cleveland, Ohio 44122