PASSPORT ADVANTAGE (HMO SNP)

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Section A: Must be completed for all authorizations

1. I hereby authorize Passport Advantage (HMO SNP) to use or disclose my health information as described below. I understand this authorization is voluntary and that Passport Advantage (HMO SNP) may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand if the person or organization authorized to receive the information is not a health plan, a health care clearinghouse, or a health care provider, the released information may no longer be protected by federal privacy regulations.

2. I understand I may revoke this authorization at any time by notifying Passport Advantage (HMO SNP) in writing at 5100 Commerce Crossings Drive, Louisville, KY 40229, but revoking will have no effect on any use or disclosure of my information made before Passport received my revocation. I also understand that a revocation will not be effective if this authorization was obtained as a condition of receiving insurance coverage and the law provides the insurer with the right to contest a claim under the policy or the policy itself.

3. Member's full name: _____

4. Member's date of birth: _____

5. Persons/organizations authorized to use and/or receive the information:

_____ _____

_____ _____

_____ _____

_____ _____

6. I authorize the following information to be used or disclosed on my behalf (check all applicable blocks):

- ☐ Appeal
- ☐ Benefits & coverage
- ☐ Billing
- ☐ Claims & payment
- ☐ Diagnosis & procedure
- ☐ Eligibility & enrollment
- ☐ Financial
- ☐ Medical records (excludes psychotherapy notes kept by a counselor separate from your medical record - these require a separate authorization)
- ☐ Physician & hospital
- ☐ Pre-certification & pre-authorization
- ☐ Referral
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Behavioral Health
- ☐ Premiums
- ☐ Other: _____

For date(s) of service from: _____ to _____

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7. I authorize the release of the following types of **sensitive information** (check all blocks that apply):

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Alcohol/substance abuse
- ☐ Genetic testing
- ☐ HIV/AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted or other communicable diseases
- ☐ Other: _____

8. List all purposes of the use or disclosure (e.g., research, marketing, payment, litigation, at your request):

_____
_____
_____.

9. This authorization will expire on (list **either** an expiration date **or** an event that relates to you or to the purpose of the disclosure, such as the end of litigation that remains ongoing. If no expiration date or event is specified, this authorization will expire one year from the date it is signed):

_____
_____
_____

Section B: Must be completed by Passport Advantage (HMO SNP) if it is requesting the authorization

1. Will Passport Advantage (HMO SNP) receive direct or indirect payment in exchange for using or disclosing the health information listed above in connection with a marketing purpose? Yes____ No____

2. Will the use or disclosure of the health information listed above be a sale of the information from which Passport Advantage (HMO SNP) will receive financial or nonfinancial benefits? Yes____ No____

NOTE: If Passport is requesting that the Member sign this authorization for its own purposes, such as marketing or research, the member (or the member's representative if signing) must receive a completed, signed copy of the authorization.

(Form must be completed before signing)

_____ _____
Signature of Member or Legal Representative Date

_____ _____
Printed Name of Member's Representative Relationship/Authority to sign