# AUTHORIZATION FOR RELEASE

## TO SHARE PROTECTED HEALTH INFORMATION (PHI)

I understand my health record is private and is known under the law as "Protected Health Information (PHI)." By completing and signing this form, I authorize Alliant Health Plans, Valence Health, its subsidiaries and affiliates to share my PHI with the people or companies listed below.

### I. MY INFORMATION

**Name** (Last, First): _____ **Date of Birth**: MM/DD/YYYY

**Street Address:** _____

**City, State, Zip Code:** _____

**ID #** (as shown on ID card)**:** _____ **Group #** (as shown on ID card): _____

### II. MY AUTHORIZATION OF THE ALLOWED USES AND DISCLOSURES OF PHI

I authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting a completed Revocation of Authorization Form to Alliant Health Plans. **Failure to answer all questions may result in this request being returned.**

**A. Organization(s) authorized to share PHI:** Alliant Health Plans, Valence Health, its subsidiaries & affiliates

**B. Individual(s) authorized to receive PHI:** _____

_____

**C. Specific information to be used or disclosed:** This authorization applies to all medical information and claims that is submitted, received, is under review, under appeal and/or processed by Alliant Health Plans, Valence Health, its subsidiaries and affiliates.

**D. Specific purpose of the disclosure:** At the request of the individual

**E. This authorization will expire 12 months from the date this form is signed unless a shorter time period is listed below.**

My authorization is valid from: MM/DD/YYYY through MM/DD/YYYY

**NOTICE TO RECIPIENT(S) OF INFORMATION (SECTION 2B ABOVE):**
Information disclosed to you pertaining to certain conditions, such as treatment for alcohol or drug abuse, HIV/AIDS and other sexually transmitted diseases, behavioral health, and genetic marker information is protected by various federal and state laws which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by such laws. Any unauthorized further disclosure in violation of state or federal law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient consent for release of these tyoes of information. The federal rule at 42 CFR Part 2 restricts use of the information disclosed to crimially investigate or prosecute any alcohol or drug abuse patient.

***Continue to page 2 to sign and date this form.***

# AUTHORIZATION FOR RELEASE (CONT'D)

## TO SHARE PROTECTED HEALTH INFORMATION (PHI)

### III. IMPORTANT INFORMATION ABOUT MY RIGHTS

I have read and understood the following statements about my rights:

- My PHI I agree to share may be sensitive. It may include diagnosis and treatment information. It may cover chronic diseases, behavioral health conditions and alcohol or drug abuse. It may cover communicable diseases, sexually transmitted diseases such as HIV/AIDS and genetic marker information.
- Alliant Health Plans will not release my PHI to the individual(s) or company(ies) named in Section 2B unless I sign and date this form.
- I may revoke this authorization at any time prior to its expiration date by notifying Alliant Health Plans in writing, but the revocation will not have any affect on any actions Alliant Health Plans, Valence Health, its subsidiaries and affiliates took before it received the revocation.
- If I do cancel my authorization, it will not affect actions taken by Alliant before the request is received.
- I may see and copy the information described on this form if I request it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used and disclosed pursuant to this authorization may be redisclosed by the receiving individual if the individual is not subject to HIPAA privacy requirements.

### IV. MY SIGNATURE

**By signing this form, I authorize Alliant Health Plans to release my PHI.**

Signature (or Signature of Legal Representative): _____ Date: MM/DD/YYYY

Printed Name (or Printed Name of Legal Representative):_____

If a legal representative signs this form, please describe the relationship: _____

**** Members 18 years of age and older must sign this form on their own behalf.***

**** If this request is being signed by the member's legal representive, you may be asked to provide legal documentation authorizing you to act on the member's behalf.***

**** If you are making a request on behalf of a minor child, we may require additional information before this request is accepted.***

**Return all pages to:**
Alliant Health Plans, ATTN: PHI Forms
1503 N. Tibbs Rd., Dalton, GA 30720
Fax: (866) 634-8917
Email: phi@alliantplans.com

**For internal use only:** ☐ **Accepted** ☐ **Denied**

## Language Assistance

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Alliant Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al (800) 811-4793.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Alliant Health Plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi (800) 811-4793.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Alliant Health Plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는(800) 811-4793 로 전화하십시오.

如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱Alliant Health Plans ]方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 (800) 811-4793。

જો તમે અથવા તમે કોઇને મદદ કરી રહ્યા હો તેમ ા ંથી કોઇને [એસબીએમ ક ર્યક્રમન ા ં ન મ મ કો] વિશે પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મેળિ નો અવિક ર છે. તે ખર્ય વિન તમ રી ભ ષ મ ા ં પ્ર મ કરી શક ર્ છે. દભ વષર્ો િ ત કરિ મ ટે,આ [અહીં દ ખલ કરો નાંબર ] પર કોલ કરો(800) 811-4793.

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Alliant Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez (800) 811-4793.

እርስዎ፣ወይም እርስዎ የሚያግዙትግለሰብ፣ ስለAlliant Health Plansጥያቄ ካላቸሁ፣ ያለ ምንም ክፍያበቋ ንቋዎ እርዳታና መረጃ የማግኘት መብት አላቸሁ። ከአስተርጓሚ ጋር ለመነጋገር፣(800) 811-4793 ይደውሉ።

यदिआपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के Alliant Health Plans के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधकिार है। ककसी भिाषषए से बात करने के लिए, (800) 811-4793 पर कॉकिरें।

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Alliant Health Plans, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan (800) 811-4793.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Alliant Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону (800) 811-4793.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Alliant Health Plans ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب (800) 811-4793.

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Alliant Health Plans, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para (800) 811-4793.

اگر شما، اي کسی که شما به او کمک مي‌کنيد ، دروم رد سوال Alliant Health Plans، داشته باشيد حق اين را داريد که کمک به زبان خود را به طور رايگان دريافت نماييد (800) 811-4793. تماس حاصل نماييد

Falls Sie oder jemand, dem Sie helfen, Fragen zum Alliant Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer (800) 811-4793 an.

ご本人様、またはお客様の身の回りの方でも Alliant Health Plans についてご質問がござ いましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、(800) 811-4793までお電話ください。

## Non-Discrimination

Alliant Health Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

## TTY/TDD

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-(800) 811-4793 (TTY/TDD: 1-(800) 811-4793).