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, on behalf of itself, subsidiaries, service providers, independent contractors and delegated entities to disclose my PHI to the individual(s) or company(ies) listed below.

I. MY INFORMATION

Name (first, last): _____ **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 PHI as described below. **If all fields are not completed, this request will not be processed.**

Specific information to use or disclose: This authorization applies to all personal demographic, medical and pharmacy information, and claims that are submitted, received, are under review, under appeal and/or processed by Alliant, on behalf of itself, subsidiaries, service providers, independent contractors and delegated entities.

A. Organization(s) authorized to use or disclose PHI: Alliant Health Plans, on behalf of itself, subsidiaries, service providers, independent contractors and delegated entities.

B. Individual(s) authorized to recieve PHI: _____

_____

C. Specific purpose of disclosure: At the request of the individual.

D. This authorization will expire 12 months from the date this form is signed unless revoked prior to the expiration date as described below. For a different time period indicate the beginning and end date.

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

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 about my rights:

Federal and state laws protect the information disclosed pursuant to this Authorization. I understand that if the authorized recipient of the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected. However, the recipient may be prohibited from disclosing any substance abuse information under the federal confidentiality requirements for alcohol and drug abuse patient records and the Public Health Service Act.

I UNDERSTAND THAT THE INFORMATION IN MY HEALTH RECORD MAY INCLUDE INFORMATION RELATING TO SEXUALLY TRANSMITTED DISEASE, ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), HUMAN IMMUNODEFICIENCY VIRUS (HIV), BEHAVIORAL OR MENTAL HEALTH SERVICES, AND/OR TREATMENT FOR ALCOHOL AND/OR DRUG ABUSE. I AUTHORIZE THE RELEASE OF SUCH INFORMATION.

Alliant Health Plans will not disclose my PHI to the individual(s) named 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 effect on any actions Alliant, on behalf of itself, subsidiaries, service providers, independent contractors and delegated entities took before it received the revocation.

If I do cancel my authorization, it will not affect actions taken by Alliant Health Plans before the request is received. I may see and copy the information described on this form if I request it.

The information that is used and disclosed pursuant to this authorization may be redisclosed by the receiving individual(s) if the individual(s) are not subject to HIPAA privacy requirements.

IV. MY SIGNATURE

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

☐ As an individual with the capacity to provide consent, my typed full name below constitutes my signature and is intended to be binding

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

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

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

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

***If this request is being signed by the individual's legal representative, you may be asked to provide legal documentation authorizing you to act on the individual'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
PO BOX 1128, Dalton, GA 30722
Fax: (866) 634 - 8917, or
Email: PHI@AlliantPlans.com

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