HIPAA AUTHORIZATION

SECTION A: BASIC INFORMATION ***Complete Section A with information about the subject of the health records:***

Member Name: _____

Address: _____

Telephone: _____ Date of Birth: _____

Member ID Number: _____ ID Number: _____

SECTION B: AUTHORIZATION ***Complete Section B to provide the authorization:***

I, the person signing this Authorization, authorize **VIRGINIA PREMIER HEALTH PLAN, INC. D/B/A VIRGINIA PREMIER** to disclose the following information:

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

for the following dates: ____/_____/_____ through _____/_____/_____ or ☐ present

to the following person or entity and any employees or agents of such entity:

_____ at:
Recipient Name

_____; _____; _____
Recipient Address *Telephone Number* *Fax Number/Email*

for the following purpose: _____.

I acknowledge that unless I state otherwise in this Authorization, the information I am requesting be released may contain substance use disorder treatment, mental health, HIV/AIDs or sexually transmitted infection (STI), or genetic testing information.

I understand that:

- My signing this Authorization is voluntary, and I may refuse to sign the Authorization. Virginia Premier may not condition my eligibility for benefits, services, or payment for treatment or other health care services on my signature.
- A copy of this Authorization and a notation concerning the recipient(s) of the disclosure will be included with my records.
- I may revoke this Authorization at any time by providing written notice to Virginia Premier at the address below. If I revoke my Authorization, it will not have any effect on any actions taken prior to receiving the revocation.
- Unless otherwise revoked, this Authorization will expire upon (specify event or date): _____. If not otherwise specified, this Authorization will expire after one (1) year.
- Any records or information released pursuant to this Authorization may no longer be covered by HIPAA and may be subject to redisclosure.

SECTION C: SIGNATURE

_____ _____
Signature of Member or Personal Representative (Ex. Parent, Guardian, Medical Power of Attorney) ***Date***

_____ _____
Printed Name ***If Signed by Personal Representative, Specify Relationship to Member***

RETURN FORM (FULLY COMPLETED) TO: Virginia Premier, Attention: Corporate Compliance, P.O. Box 5307, Richmond, VA 23220-0307. Fax: (877) 307-1636; Telephone: (804) 819-5173, Toll-free: (800) 727-7536.

YOU ARE ENTITLED TO A COPY OF THIS REQUEST.