

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION/ACCESS REQUEST FORM

Section 1 I authorize **Community Health Plan**, 137 North Belt Highway, St. Joseph, MO 64506 to release:

Check all that apply

Claims Records

Eligibility Records

Member Contact Records

Referral Records

Prior Authorization Records

Case Management Records

Disease Management Records

All

(Individual name)

(Date of birth)

(Address)

(Telephone)

These records may be released to:

(Name)	(Relationship)	(Name)	(Relationship)
(Name)	(Relationship)	(Name)	(Relationship)

Information will be used/disclosed for the following purpose(s):

Section 2 **Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release**

If my records contain information about drug and/or alcohol abuse, mental health, sexually transmitted diseases and/or other sensitive information, I agree to its release.

Drugs Yes No HIV/AIDS Yes No Sexually Transmitted Disease Yes No

Alcohol Yes No Mental Health Yes No

Section 3 **Time Limit / Right to Revoke**

This authorization will expire 90 days from the day of my signature or on the following date or event (please specify):

If I want to cancel this authorization before it expires, I must submit a written notice to the Privacy Officer at Community Health Plan. It is understood that information released prior to my written cancellation was made at my request and with my consent.

Section 4 **Re-disclosure**

I understand that the information disclosed by this authorization could be re-disclosed by the person receiving it and is no longer protected by federal or state legal privacy requirements. Community Health Plan, its affiliates, its employees, and officers are not legally responsible or liable for the re-disclosure of the information indicated on this authorization.

Section 5 **Signature of Individual or Personal Representative Who May Request Disclosure**

I understand that I do not have to sign this authorization, that my treatment or payment for services will not be denied if I do not sign this Authorization, and that I can inspect or copy the Protected Health Information to be used or disclosed.

I hereby authorize Community Health Plan to release the Protected Health Information as specified above.

Signature of Individual or Individual's Representative

Date

Printed Name of Individual or Individual's Representative

Relationship of Individual's Representative

The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules and state law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse Individual.