Authorization for the Use or Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Cox HealthPlans, LLC may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information (PHI) described herein.

Release To: ______________________ Release From: ______________________

______________________ ______________________

______________________ ______________________

Patient Identification

Printed Name: ______________________ Date of Birth: ______________________

Address: ______________________ Telephone#: ______________________

______________________ Social Security #: ______________________

Information To Be Released - Covering the Periods of Health Care:

From (Date): ______________________ To (Date): ______________________

Please check the type of information to be released:

- [ ] Complete Health Record
- [ ] History & Physical Exam
- [ ] Laboratory Test Results
- [ ] Diagnosis & Treatment Codes
- [ ] Consultation Reports
- [ ] X-ray Reports
- [ ] Photographs, videotapes
- [ ] Complete Billing Record
- [ ] Itemized Bill
- [ ] Discharge Summary
- [ ] Progress Notes
- [ ] X-ray Films & Images
- [ ] Other (Please specify): ______________________

Purpose of Request (please check):

- [ ] Treatment or Consultation
- [ ] At the request of the patient
- [ ] Billing or Claims Payment
- [ ] Other (Please specify): ______________________

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

I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, psychological care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information, I agree to its release.

- [ ] Yes
- [ ] No

I understand that if I authorize the release of Drug & Alcohol Abuse treatment records (such as from Center for Addictions) that Federal Law protects those records. The Authorization for Release of Information form does not authorize re-disclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, prohibit information disclosed from records protected by this law from being re-disclosed, even to the patient, without specific written consent of the patient or as otherwise permitted by such law/and or regulations. A general authorization for the release of medical or other information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

- [ ] Yes
- [ ] No

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the Home Office of Cox HealthPlans, LLC at P.O. Box 5750, Springfield, MO 65801-5750. Unless revoked, this authorization will expire on the following date or event: ______________________, or one year from the date of signature, unless otherwise specified.

Re-disclosure

I understand that once information is released to the above named person or persons, my information may be subject to re-disclosure. I understand that once information is released, it may be re-disclosed by the recipient and no longer protected by federal privacy regulations. I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless it is for research-related treatments or provided solely to give information to a third party as specified under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.

Signature: ______________________ Date: ____________ Relationship to Patient: ______________________

(Patient, parent if minor, legal guardian)

Identity of Requester Verified via: (For Office Use Only)

- [ ] Photo ID, Matching Signature
- [ ] Other, specify: ______________________ Verified by: ______________________