Dear Current/Former Member:

Enclosed is the Community Health Options (Health Options) ***Authorization for Disclosure of Protected Health Information (PHI)*** form you recently requested. Please complete all four sections of the form. **Incomplete forms cannot be processed**. Here are some helpful instructions for completing the form:

- **Print your full name, date of birth, and complete Member ID number in the corresponding fields on the first three lines of the form.**

- Your authorization to disclose your Protected Health Information (PHI) requires the name, address, and telephone number of the individual person you wish to have us disclose the information to. **An authorization without a specific individual's name will be considered invalid and only one person may be specified on each form.**

- **Indicate the information that Health Options can disclose.** There are two sections to review and two options to choose from in each of the sections as they may apply to you.

  In the first section we require you to choose one box. If you chose the "limited information" option box to be disclosed, be sure to check the specific circle(s) for which you want limited disclosure.

  The second section is for disclosure of sensitive information and is optional. If you do not want sensitive information disclosed do not check any boxes. If you chose the "just information about topics" option box to be disclosed, be sure to check the specific circle(s) for which you want limited disclosure.

- <u>You must sign and date the form.</u>

Send us the completed form by either Mail, Fax or Email

Mail to: Privacy Officer, Community Health Options, Mail Stop 100, PO Box 1121, Lewiston, ME 04243

Fax to: Attn: Privacy Officer, Community Health Options, 207-402-3745

Should you have questions about this form, call our Member Services team (855) 624-6463, Monday through Friday, 8 AM – 6 PM.

Sincerely,

Member Services
Community Health Options

NON-DISCRIMINATION NOTICE

Community Health Options does not view or treat people differently because of their race, color, national origin, sex, age or disability. If you need help with any of the information we provide you, please let us know. We offer services that may help you. These services include aids for people with disabilities, language assistance through interpreters and information written in other languages. These are free at no charge to you. If you need any of these services, please call us at the number on the back of your member ID card.

If you feel at any time that we didn't offer these services, or we discriminated based on race, color, national origin, sex, age or disability, please let us know. You have the right to file a grievance, also known as a complaint. If you need help filing a complaint, please contact Nancy Johnson, Assistant Vice President of Compliance and Regulatory Affairs at P.O. Box 1121, Lewiston, ME 04243; by telephone at 1-855-624-6463 TTY/TDD 711; by email at Compliance@HealthOptions.org; or by fax to 207-402-3318.

You can also contact the U.S. Department of Health and Human Services at the Office for Civil Rights at:

- **Online:** https://ocrportal hhs.gov/ocr/portal/lobby.jsf
- **Mail:** U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
- Phone: 1.800.368.1019 or 1.800.537.7697 (TDD)
- Complaint forms are available at http://www.hhs.gov/ocr/office/file/index html.

French ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le 1-855-624-6463 (TTY/TDD: 711)	Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-624-6463 (TTY/TDD: 711)	Chinese 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-624-6463 (TTY/TDD: 711)。
Cushite XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-624-6463 (TTY/TDD: 711)	Vietnamese CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-624-6463 (TTY/TDD: 711)	Arabic ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 1-855-624-6463 رقم والبكم الصم هـ: TTY/TDD 711.
Cambodian, Mon-Khmer ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-624-6463 (TTY/TDD: 711)។	Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-624-6463 (телетайп: 711)	Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1855-624-6463 (TTY/TDD: 711).
German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-624-6463 (TTY/TDD: 711).	Thai เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-624-6463 (TTY/TDD: 711).	Nilotic-Dinka PIŊ KENE: Na ye jam në Thuɔŋjäŋ, ke kuɔny yenë kɔc waar thook atö kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 1-855-624-6463 (TTY/TDD: 711).
Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-624-6463 (TTY/TDD: 711) 번으로 전화해 주십시오.	Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-624-6463 (TTY/TDD: 711).	Japanese 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-624-6463 （TTY/TDD: 711 ）まで、お電話にてご連絡ください。

Authorization for Disclosure of Protected Health Information

Current/Former Member's Full Name: _____

Current/Former Member's Date of Birth: _____

Current/Former Member ID#: _____

This will authorize **Community Health Options (Health Options)** and its employees to disclose my Protected Health Information (PHI) to: *(name only one person per form)*

ADAP	286 Water Street, 6th Floor,Augusta, ME 04333
Name of Authorized Representative	**Address/City/State/ZIP**
207-287-7028	207-287-3498
Phone #	Fax #

I authorize the disclosure of the following types of information by Health Options:
(Required, check one box below)

☑ All my information. This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). **This doesn't include sensitive information (see box below) unless it is approved below.**

OR

☐ Only limited information may be released (check all circles below that apply to you).

- ○ Appeal
- ○ Benefits and coverage
- ○ Claims and payment
- ○ Diagnosis (name of illness or condition) and procedure (treatment)
- ○ Eligibility and enrollment
- ○ Financial
- ○ Invoicing
- ○ Medical records
- ○ Doctor and hospital
- ○ Pre-certification and pre-authorization (for treatment approvals)
- ○ Referral
- ○ Treatment
- ○ Dental
- ○ Vision
- ○ Pharmacy
- ○ Other: _____

I authorize the disclosure of the following types of sensitive information by Health Options:
(Optional, check one box below only if it is applicable)

☑ All Sensitive Information

OR

☐ Just information about topics (checked all circles below that apply to you)

- ○ Abortion
- ○ Abuse (sexual/physical/mental)
- ○ Alcohol/substance abuse **
- ○ Genetic testing
- ○ HIV of AIDS
- ○ Maternity
- ○ Mental Health (excluding psychotherapy notes)
- ○ Sexually transmitted illness
- ○ Other: _____

**I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I understand that I cannot cancel this approval when this form has already been used to disclose information.

By signing below:

I intend this authorization to apply to disclosures of PHI that Health Options has received from other persons or entities. I authorize that subsequent disclosures of PHI within the scope of this authorization may be made pursuant to this same authorization.

I understand that I am entitled to a copy of this authorization.

I understand that this authorization may be revoked in writing and delivered to the Privacy Officer of Health Options at any time, although revocation will not be effective to the extent anyone has already relied on the authorization.

I understand that PHI used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I understand that Health Options shall not condition treatment, payment or enrollment in a health plan or eligibility for benefits on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.

Current Members: This authorization will expire 2 years from the date of the signature or when the policy is no longer active – whichever comes first.

If you prefer a shorter time in which this authorization is valid, please indicate the date it would expire:_____

Former Members: This authorization will expire after 1 year from the date of the signature.

If you prefer a shorter time in which this authorization is valid, please indicate the date it would expire:_____

_____ _____

Signature of current/former Member (or their Legally Authorized Representative*) **Date**

_____

*Authority or relationship of authorized representative

Send us the completed form by either Mail, Fax or Email

Mail to: Privacy Officer, Community Health Options, Mail Stop 100, PO Box 1121, Lewiston, ME 04243

Fax to: Attn: Privacy Officer, Community Health Options, 207-402-3745 ♦ Email to: Enrollment@HealthOptions.org

For questions on how to fill out this form, call Member Services on 855-624-6463