Advantage MD

JOHNS HOPKINS HEALTH PLANS

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

By completing this document, you authorize the disclosure and/or use of your individually identifiable health information, as set forth below, consistent with Federal law concerning the privacy of such information. Failure to provide all information may invalidate this Authorization.

Member Demographics:

Name: _____

Address: _____

ID Number: _____ Date of Birth: _____

1. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ (your name), authorize Johns Hopkins Advantage MD (HMO) and Johns Hopkins Advantage MD (PPO) to disclose my health information.

Person/Organization I authorize to receive my health information:

Name/Organization: _____

Address: _____

City, State and Zip: _____

Phone Number: _____

What relationship is this person to you? _____

This Authorization applies to **All Health Information** including health (e.g., diagnosis, providers, treatments, drugs), eligibility, enrollment and financial information (e.g., medical claims, premium bills, copayments), substance abuse, mental health, HIV, etc.

2. DESIGNATION OF PERSONAL REPRESENTATIVE

As required by the Health Information Portability and Accountability Act if 1996, you have a right to nominate one or more persons to act on your behalf with respect to your protected health information (PHI). Your Personal Representative is given all of the privileges that you have with respect to your PHI. Your Personal Representative may receive your PHI and also has the authority to modify your Johns Hopkins Advantage MD health plan account (e.g., update your address change your Primary Care Physician). A personal representative may be a spouse, relative, domestic partner or friend.

You are not required to have a Personal Representative, but if you want to designate someone who can receive your PHI and modify your Johns Hopkins Advantage MD health plan account, please complete the information below and attach appropriate documentation authorizing the representation (e.g., Power of Attorney [POA]).

The person named below (same as individual named in Section 1) is to also be given all of the privileges that would be given to me regarding my protected health information.

Personal Representative Name: _____
(Individual named in Section 1)

3. EXPIRATION

This document will be in effect until my coverage with Johns Hopkins Advantage MD health plan ends or until I send a written request to revoke this authorization.

4. NOTICE OF RIGHTS AND OTHER INFORMATION

- I may refuse to sign this authorization. I understand that Johns Hopkins Advantage MD health plan will not condition treatment, payment, enrollment or eligibility for benefits on my providing or refusing to provide this authorization, except under limited circumstances described in the Notice of Privacy Practices.
- I may revoke this authorization at any time by signing the revocation section and sending this for to Johns Hopkins Advantage MD health plan. My revocation will be effective upon receipt but will not be effective to the extent that other have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.
- I understand information disclosed pursuant to this authorization could be re-disclosed by the recipient and might not be protected by federal confidentiality law (HIPAA).
- I may inspect or obtain a copy of the health information I am authorizing for use or disclosure.
- I understand that Johns Hopkins Advantage MD health plan may not use or disclose my PHI other than for the purposes described on this form unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.
- I hereby release Johns Hopkins Advantage MD health plan from any and all liability that may arise from the release of this information to the party named on this form.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

5. SIGNATURE

Please print your name: _____

Johns Hopkins Advantage MD health plan ID number: _____

Signature: _____ Date: _____

If signed by someone other than the member (such as a guardian or conservator), please complete the following:

Printed name: _____ Relationship: _____

6. SUBMISSION

All pages of this form must be faxed or mailed to:

Johns Hopkins Advantage MD
P.O. Box 3538
Scranton, PA 18505
Fax: 1-855-206-9203

7. REVOCATION

You may revoke this authorization at any time by signing and dating this section of the form and returning it to Johns Hopkins Advantage health plan. You should only sign this section if you want to cancel this authorization.

I hereby revoke this authorization and/or designation or personal representative immediately.

Signature: _____ Date: _____