MEMORIAL HERMANN | Health Plan
Medicare *Advantage* Plans
Health Plan Commercial Groups

Instructions for Completing
Authorized Representative Form
To Complete Form go to Page 4 of 5

Use this form to authorize Memorial Hermann Health Solutions, Inc., Memorial Hermann Health Insurance Company, Memorial Hermann Health Plan, Inc. or Memorial Hermann Commercial Health Plan, Inc. (collectively "MHHSI") to disclose your protected health information (PHI) to a specific person or entity. You may follow the instructions we provided below or you may call the Customer Service number listed on the back of your Membership Identification card for assistance in completing the form. You must complete all the fields on this form.
Please remember:

- One **authorization form** can be used for a range of and/or multiple services or providers.
- **Authorization** forms can be completed claim by claim, procedure by procedure, or for services within specified timeframes.
- The **individual's** use of the **authorization form** is always voluntary.

I. **Individual** (Name and information of person whose protected health information is being disclosed):

Jane Doe		05-10-1963
Name		Date of Birth
123456	XOP123456789	###-##-#If.##
Group#	Subscriber ID#	Social Security Number

123 Spring Street	Anytown	TX	12345
Address	City	State	ZIP

312-555-1212
Area Code & Telephone Number

All of the information in **Section** I pertains to the individual for whom the authorization is being requested. The individual may be the subscriber, his or her spouse, a dependent or any other **individual** covered or applying for coverage under the subscriber's membership. All fields in this section are **required.** In this example, Jane Doe is the individual for whom the authorization is being requested.

II. Authorization and Purpose:

I request and authorize MHHSI to disclose my protected health information as described below. I **understand that** if **the person/ organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.**

Suzy Doe	Sister	Assisting in medical care
Persons/Organizations authorized to receive your information	Relationship	Purpose

123 Cherry Road	Happytown	TX	45678
Address	City	State	ZIP

Section II identifies the person/entity that will be receiving the PHI about the individual identified in Section I. An individual could authorize disclosure of his or her PHI to a close friend, a broker, an attorney, or a specific member of his or her employer's benefits staff. The individual may also authorize disclosure to an organization. Include the information identifying the organization's job titles to receive the PHI (e.g., Benefits Representatives, Human Resources Department, XYZ Insurance Agency, etc.). In this example, Jane Doe has identified her sister, Suzy Doe as the person who is authorized to receive her information.

III. Specific Description of Information to be Used or Disclosed

*(Please Complete **Parts A and B** in this Section)*

This Authorization CANNOT be used to disclose Psychotherapy Notes.

Section III will assist in determining what PHI the individual identified in Section I allows the receiving person/entity identified in Section II to receive. This section has two parts, both of which must be completed.

A. Release of Sensitive Protected Health Information Under State Law

You must check "yes" or "no" if you authorize the release of medical information, test results, records or communications specific to ***(note: 'yes" means this information is included in the categories you designate in Part B below)***

- Human Immunodeficiency Virus **(HIV)** or HIV/Acquired Immune Deficiency Syndrome
- Sexually transmitted or "communicable" diseases (includes hepatitis, as well as venereal diseases);
- Drug, alcohol or substance abuse;
- Mental health or developmental disabilities (including mental retardation or similar disabilities, for example, those attributable to cerebral palsy, autism or neurological dysfunctions); and
- Genetic testing.

Yes ☒

No ☐

Section III **A.** asks if the authorizing individual identified in Section I wants the receiving person/entity identified in Section II to receive ***Sensitive*** Protected Health Information (SPHI). SPHI are certain types of health information for which various states' laws require extra protections. Either **"Yes"** or **"No"** must be chosen. In this example, Jane has agreed to let Suzy receive her SPHI.

B. Release of Protected Health Information *(check one or more)*

			Dates of Services From:	To:
☐	Health Plan Benefit Information:	Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).		
☒	Claims Information:	Includes information related to payment of your claims for service you received, including pertinent information located on a claim form (i.e., billed amount, general procedure descriptions claim payment or denial reasons, etc.).	6-12-05	4-30-08
☐	Service Determination Information:	Includes any information related to pre-service, concurrent and post-service decisions.		
☐	Premium	Includes information related to billing cycles, bank draft changes, etc.		
☐	Services from (provider or supplier):	Provider name: _____ (Includes information related to services rendered by a specific provider or supplier.)		
☐	Other:	_____ (Specify other information that is not listed in one of the categories above.)		

Section III **B.** asks for the specific types of information that the individual identified in Section I is authorizing MHHSI to disclose to the person/entity identified in Section II. In this example, Jane is authorizing MHHSI to provide her daughter with her claims information for the time period listed. "Dates of Service" means disclosing information for health care services the individual received during a particular time period. For example, in this case Jane Doe is authorizing MHHSI to disclose claims information for health care services provided during June 12, 2005 through April 30, 2008.

IV. Expiration and Revocation:

This authorization is valid until the earlier of the occurrence of:

- the death of the individual;
- the individual reaching the age of majority;
- permission is withdrawn **(must be in writing);** or
- the following specific date (**optional):** Month ____ Day _____ Year_____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. I **understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.**

Section IV. asks for the "expiration" date and a statement regarding the individual's right to revoke. All valid authorizations must contain a specific expiration date or expiration event (e.g. ***"hospitalization end date", "rehabilitation end date",*** etc). In this example, the authorization will remain valid for a period of one year from the date it was signed, or until Jane revokes the authorization. **This authorization may not exceed 24 months from the date of execution.**

V. Signature (this document must be signed by the individual, parent of minor child or the individual's personal representative):

I understand that this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

Jane Doe _____ 4-30-08

Signature **Date: month/day/year**

If **you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and attach a copy of the Legal documents. You do NOT have to attach copies of these documents** if **they are already on file with MHHSI.**

Personal Representative's Name **Relationship to Individual**

Personal Representative's Address **City** **State** **ZIP**

Personal Representative's Area Code & Telephone Number

Section V. requires the signature and date. In order to be valid, the authorization form must be signed by either the individual identified in Section I or the individual's personal representative identified in Section V. If the individual is a minor dependent under the age of 18, a parent or guardian may sign the authorization form. A personal representative has received legal authority to represent the individual. In this case, since Jane is completing the form, there is no need for a personal representative to sign. If Jane's personal representative were signing this authorization on her behalf, the personal representative must complete the lower portion of Section V and submit the proper documentation with the authorization form (if not already on file with MHHS).

BEFORE SENDING AUTHORIZATION FORM
YOU SHOULD KEEP A COPY FOR YOUR
RECORDS BY EITHER:

(1) MAKING A PHOTOCOPY OF TIDS SIGNED AUTHORIZATION; OR
(2) COMPLETING AND SIGNING THE DUPLICATE AUTHORIZATION FORM YOU RECEIVED OR PRINTED

The final portion of the form contains some instructions to be followed prior to mailing the form to MHHSI. Members are advised to keep a signed copy for their records.

MEMORIAL HERMANN | Health Plan
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Authorized Representative Form To Use or Disclose Protected Health Information (PHI)

I. Individual (Name and information of person whose protected health information is being disclosed):

Name _____ Date of Birth _____

Group# _____ Subscriber ID # _____ Social Security Number _____

Address _____ City _____ State _____ ZIP _____

Area Code & Telephone Number _____

II. Authorization and Purpose:

I request and authorize MHHSI to disclose my protected health information as described below. I **understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.**

Persons/Organizations authorized to receive your information _____ Relationship _____ Purpose _____

Address _____ City _____ State _____ ZIP _____

III. Specific Description of Information to be Used or Disclosed *(Please Complete **Parts A and B** in this Section)*

This Authorization CANNOT be used to disclose Psychotherapy Notes.

A. Release of Sensitive Protected Health Information Under State Law

You must check "yes" or "no" if you authorize the release of medical information, test results, records or communications specific to ***(note: 'yes" means this information is included in the categories you designate in Part B below)***

- Human Immunodeficiency Virus **(HIV)** or HIV/Acquired Immune Deficiency Syndrome
- Sexually transmitted or "communicable" diseases (includes hepatitis, as well as venereal diseases);
- Drug, alcohol or substance abuse;
- Mental health or developmental disabilities (including mental retardation or similar disabilities, for example, those attributable to cerebral palsy, autism or neurological dysfunctions); and
- Genetic testing.

Yes ☐
No ☐

B. Release of Protected Health Information *(check one or more)*

			Dates of Service From:	To:
☐	Health Plan Benefit Information	Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).		
☐	Claims Information:	Includes information related to payment of your claims for service you received, including pertinent information located on a claim form (i.e., billed amount, general procedure descriptions claim payment or denial reasons, etc.).		
☐	Service Determination Information:	Includes any information related to pre-service, concurrent and post-service decisions.		
☐	Premium	Includes information related to billing cycles, bank draft changes, etc.		
☐	Services from (provider or supplier):	Provider name: _____ (Includes information related to services rendered by a specific provider or supplier.)		
☐	Other:	_____ (Specify other information that is not listed in one of the categories above.)		

IV. Effective Time Period and Revocation:

This authorization is valid until the earlier of the occurrence of:

- the death of the individual;
- the individual reaching the age of majority;
- permission is withdrawn (must be in writing); or
- the following specific date (optional): Month _____ Day _____ Year __

This authorization may not exceed 24 months from the date of execution.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. I **understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.**

V. Signature (this document must be signed by the individual, parent of minor child or the individual's personal representative):

I understand that this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_____ _____

Signature **Date: month/day/year**

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and attach a copy of the Legal documents. You do NOT have to attach copies of these documents if they are already on ftle with MHHSI:

_____ _____

Personal Representative's Name **Relationship to Individual**

_____ _____ _____ _____

Personal Representative's Address **City** **State** **ZIP**

_____

Personal Representative's Area Code & Telephone Number

BEFORE RETURNING THIS FORM YOU SHOULD KEEP A COPY FOR YOUR RECORDS BY EITHER: (1) MAKING A PHOTOCOPY OF THIS SIGNED AUTHORIZATION; OR (2) COMPLETING THE DUPLICATE AUTHORIZATION FORM YOU RECEIVED OR PRINTED

Mail your completed signed authorization to;
Attn: Customer Service
PO Box 19909
Houston, TX 77224
or fax to: 713.338.6550

If you need assistance completing the form, please refer to the instructions above or contact the Customer Service number listed on the back of your Member Identification Card.

Any changes to the format, content or branding of this form are strictly prohibited without review and approval of the HCSC Privacy Office. Please contact the Privacy Office with any change requests.

Memorial Hermann Health Solutions provides administrative services for itself and for Memorial Hermann Health Insurance Company, who writes PPO coverage, Memorial Hermann Health Plan, Inc. which writes HMO coverage and Memorial Hermann Commercial Health Plan, Inc. which writes HMO coverage.