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1-877-509-4979 | 605-910-6519
TTY 711 | Fax: 715-221-9500

HIPAA Use and Disclose Protected Health Information Authorization

Form to be used if member wishes to allow release of information to a third party.
Sections A, B and D must be completed. A signature on page 2 is required to make the authorization valid.

Section A – Information about Align powered by Sanford Health Plan member in question

Name (last, first, middle) _____ Subscriber no. _____

Address _____

Phone (_____) _____ Date of birth (m/d/y) _____ /_____ /_____

MY HEALTH INFORMATION. The health information that is subject to this authorization consists of all health information about me created or received by Align powered by Sanford Health Plan, including the following types of records: medical, dental, alcohol and/or drug abuse, psychiatric/psychological (excluding psychotherapy notes*), developmental disabilities, case or medical management, billing, payment, claims and enrollment. It includes records of the diagnosis by a member of the medical profession of, or treatment for, acquired immunodeficiency syndrome (AIDS) or AIDS-related complex (ARC). It does not include any records of tests at anonymous counseling and testing sites or through the use of an anonymous home test kit to detect the presence of human immunodeficiency virus (HIV), antigen and non-antigenic products of HIV or antibody to HIV.

* Psychotherapy notes are notes recorded by a mental health professional that document or analyze the conversation during a private, group, joint or family counseling session and that are separated from the rest of my medical record. Psychotherapy notes do not include medication prescription and monitoring, counseling session start and stop times, the types and frequencies of treatment, clinical test results, or any summary of diagnosis, functional status, treatment plan, symptoms, prognosis or progress to date.

Section B – Individuals who you want to have access to your information

AUTHORIZED DISCLOSURE. I authorize Align powered by Sanford Health Plan to disclose my health information described above to:

Name(s) _____ Relationship to member _____

Address _____ Phone (_____) _____

Name(s) _____ Relationship to member _____

Address _____ Phone (_____) _____

Name(s) _____ Relationship to member _____

Address _____ Phone (_____) _____

for the following specific purpose(s): payment matters including claim handling, prior authorization requests, membership and enrollment inquiries; health care operations including customer service, grievance or appeal matters, care coordination and additional purposes as described.

Additional names may be added to a separate page.

(continued)

Section C – Term and other information

TERM. This authorization will remain in effect until the following date or event occurs

_____, (indicate a date/event or leave blank)
or until I am no longer covered by Align powered by Sanford Health Plan, whichever occurs earlier, unless I revoke this authorization in writing (at any time) as described in the Align powered by Sanford Health Plan Notice of Privacy Practices (copy available upon request).

I understand Align powered by Sanford Health Plan will not condition my enrollment or my eligibility for benefits on my providing this authorization.

I understand that once Align powered by Sanford Health Plan discloses my health information to the person named above, in accordance with this authorization, it is possible that the information could be redisclosed by that person and no longer protected by applicable federal and state law governing the use and disclosure of my health information.

I understand that I will receive a copy of this signed authorization.

Section D – Signature

I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the disclosure of my health information. I knowingly and voluntarily authorize disclosure of my health information as described above.

_____ _____ /_____ /_____

Signature **Date (m/d/y)**

If member is unable to sign this authorization, please complete the information below:

_____ _____ _____ /_____ /_____

Signature of authorized legal guardian, health care agent, or other authorized personal representative **Relationship** **Date (m/d/y)**

(A copy of guardianship or other supporting documents must be provided to Align powered by Sanford Health Plan if a signature appears here.)

Note to recipient of drug and alcohol abuse information: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules 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 patient.

Retain a copy of this authorization for your records.

Notice of Nondiscrimination

Sanford Health Plan and Sanford Health Plan of Minnesota have HMO, PPO, I-SNP and D-SNP plans with a Medicare contract and contracts with state Medicaid programs. Enrollment in these plans depends on contract renewal. Sanford Health complies with applicable federal civil rights laws and does not discriminate, exclude or treat people differently on the basis of race, color, national origin, religion, pregnancy and related conditions, sex (including sexual orientation, gender identity, sex stereotypes, sex characteristics and intersex traits), age, disability, health status, marital status, arrest or conviction record or military participation in the administration of the plan, including enrollment and benefit determinations.

Limited English Proficiency Language Services

English: Free interpretation services are available to you. Additional services and resources necessary to provide information on accessible formats are also available at no cost. Call 1- 877-509-4979 (TTY: 711) or speak with your healthcare provider.

Spanish: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1- 877-509-4979 (TTY: 711) o hable con su proveedor.

Oromo: Yoo afaan Oromoo dubbattu ta'e, tajaajilli gargaarsa afaanii bilisaa siniif ni argama. Gargaarsi gargaaraa fi tajaajilli sirrii ta'ee fi odeeffannoo bifa dhaqqabamaa ta'een kennuunis bilisaan ni argama. Bilbilaa 1- 877-509-4979 (TTY: 711) yookiin dhiyeessaa kee waliin haasa'aa.

If you require materials in large print, call 1-877-509-4979 (TTY 711).