Instructions for Completing the Authorization for Disclosure of Sensitive Health Information Form

If you have any questions, please feel free to call us at the customer service number on your member identification card.

Please read the following for help completing page one of the form.

1 **This form is to be used by members to authorize the release of their sensitive health information for purposes of the the Centers for Medicare and Medicaid Services (CMS) and Office of the National Coordinator for Health Information Technology (ONC) Interoperability and Patient Access API Rule only.**

PART A: Member Information

This section applies to the member who is asking for the release of his or her sensitive health information to another person or company.

2 Print your first name, middle initial and last name.

3 Write your Identification number - You will find this number on your member identification card.

4 Write your full street address, city, state, and zip code.

5 Write your date of birth.

6 Write your daytime phone number (including area code).

PART B: Health Plan that will release your information

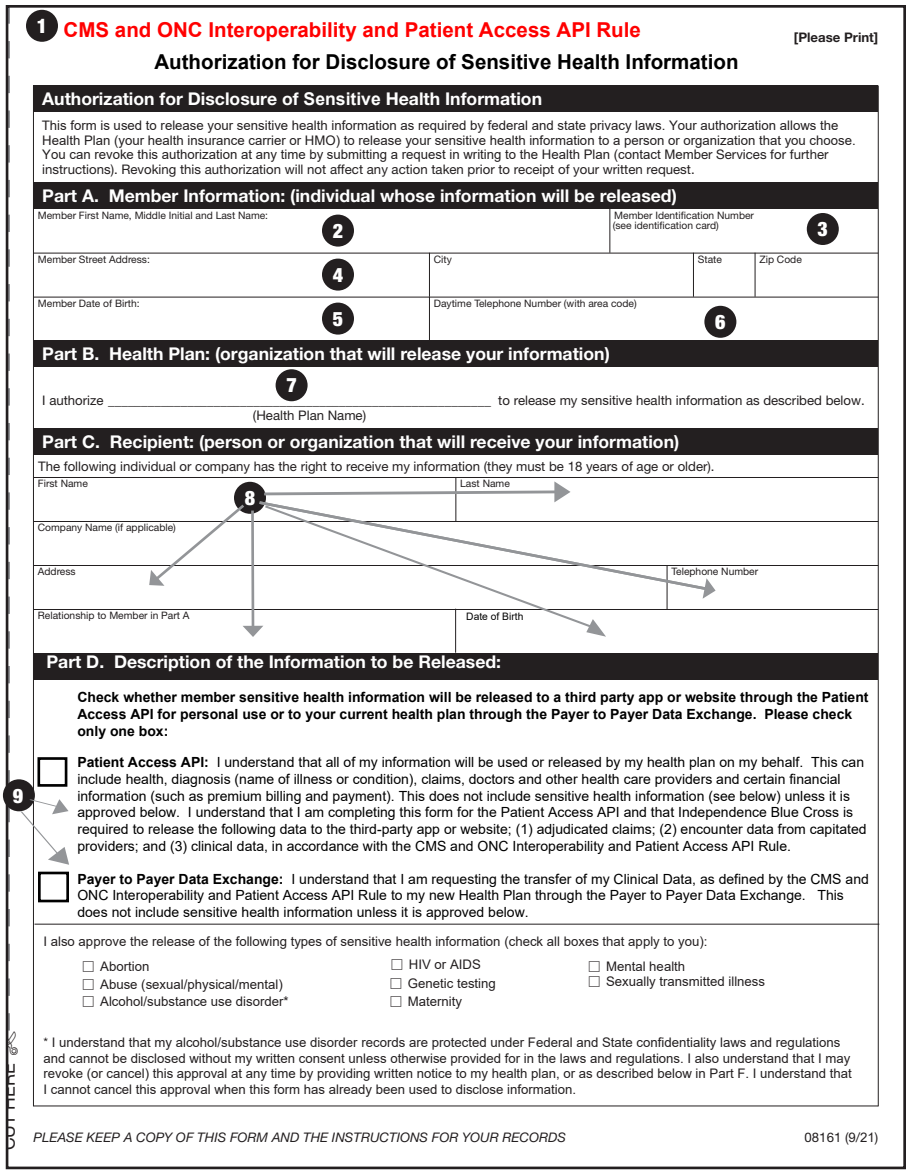
7 Print the name of the Health Plan that will release the member's sensitive health information.

PART C: Recipient - Person or organization that will receive your information

8 **Patient Access API**: In order to release your sensitive health information to a third party app or website for your parent/guardian's or Personal Representative's use, please provide the recipient's full legal name, address, telephone number, and date of birth in the appropriate boxes.

If you are a Keystone HMO CHIP member requesting the release of sensitive health information to your guardian/ parent, please indicate that they are the Head of Household in the "Relationship to Member in Part A" box.

Payer to Payer Data Exchange: In order to release your sensitive health information to your new Health Plan through the Payer to Payer Data Exchange, please provide the name of the Health Plan, address and telephone number in the appropriate boxes.



1 CMS and ONC Interoperability and Patient Access API Rule

[Please Print]

Authorization for Disclosure of Sensitive Health Information

Authorization for Disclosure of Sensitive Health Information

This form is used to release your sensitive health information as required by federal and state privacy laws. Your authorization allows the Health Plan (your health insurance carrier or HMO) to release your sensitive health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to the Health Plan (contact Member Services for further instructions). Revoking this authorization will not affect any action taken prior to receipt of your written request.

Part A. Member Information: (individual whose information will be released)

Member First Name, Middle Initial and Last Name: **2** | Member Identification Number (see identification card) **3**

Member Street Address: **4** | City | State | Zip Code

Member Date of Birth: **5** | Daytime Telephone Number (with area code) **6**

Part B. Health Plan: (organization that will release your information)

I authorize **7** _____ to release my sensitive health information as described below.
(Health Plan Name)

Part C. Recipient: (person or organization that will receive your information)

The following individual or company has the right to receive my information (they must be 18 years of age or older).

First Name | Last Name **8**

Company Name (if applicable)

Address | Telephone Number

Relationship to Member in Part A | Date of Birth

Part D. Description of the Information to be Released:

Check whether member sensitive health information will be released to a third party app or website through the Patient Access API for personal use or to your current health plan through the Payer to Payer Data Exchange. Please check only one box:

☐ **9** **Patient Access API:** I understand that all of my information will be used or released by my health plan on my behalf. This can include health, diagnosis (name of illness or condition), claims, doctors and other health care providers and certain financial information (such as premium billing and payment). This does not include sensitive health information (see below) unless it is approved below. I understand that I am completing this form for the Patient Access API and that Independence Blue Cross is required to release the following data to the third-party app or website; (1) adjudicated claims; (2) encounter data from capitated providers; and (3) clinical data, in accordance with the CMS and ONC Interoperability and Patient Access API Rule.

☐ **Payer to Payer Data Exchange:** I understand that I am requesting the transfer of my Clinical Data, as defined by the CMS and ONC Interoperability and Patient Access API Rule to my new Health Plan through the Payer to Payer Data Exchange. This does not include sensitive health information unless it is approved below.

I also approve the release of the following types of sensitive health information (check all boxes that apply to you):

☐ Abortion
☐ Abuse (sexual/physical/mental)
☐ Alcohol/substance use disorder*
☐ HIV or AIDS
☐ Genetic testing
☐ Maternity
☐ Mental health
☐ Sexually transmitted illness

* I understand that my alcohol/substance use disorder 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 also understand that I may revoke (or cancel) this approval at any time by providing written notice to my health plan, or as described below in Part F. I understand that I cannot cancel this approval when this form has already been used to disclose information.

PLEASE KEEP A COPY OF THIS FORM AND THE INSTRUCTIONS FOR YOUR RECORDS

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PART D: Description of the Information to be Released - This section explains the information we will release through the Patient Access API or the Payer to Payer Data Exchange.

9 **Check whether member sensitive health information will be released through the Patient Access API or the Payer to Payer Data Exchange. Please check only one box.**

Patient Access API: Please indicate what sensitive health information you would like to release by checking the applicable boxes. All of your information, except sensitive health information, will be released to a third-party app or website for your or your representative's use. This can include health, diagnosis (name of illness or condition), claims, doctors and other health care providers and certain financial information (such as premium billing and payment).

Payer to Payer Data Exchange: Please indicate what sensitive health information you would like to release by checking the applicable boxes. Clinical Data, as defined by the CMS and ONC Interoperability and Patient Access API Rule will be released to your new Health Plan through the Payer to Payer Data Exchange

NOTE: For the release of sensitive health information (e.g. HIV/AIDs, drug and alcohol use disorder, mental health, genetic testing), you must check the box(es) that apply to you.

Instructions for Completing the Authorization for Disclosure of Sensitive Health Information Form

If you have any questions, please feel free to call us at the customer service number on your member identification card.

Please read the following for help completing page two of the form.

PART E: Purpose of this approval -
This section tells us the reason you've asked for the release of your information.

10 The purpose of this approval is to release sensitive health information for the purposes of the CMS and ONC Interoperability and Patient Access API Rule .

Part F. Expiration date of this approval

This authorization will remain in full force and effect until and unless: (1) the member revokes this authorization in writing to the health plan*; or (2) the member turns 18 years of age, in which case this authorization will be automatically revoked.

11

*The health plan identified in Section B must be notified in writing of the member's revocation of this authorization. Such revocation shall not impact or be applicable to any data released prior to health plan's receipt and processing of the member's revocation. A request for revocation can be forwarded to the address at the bottom of this form.

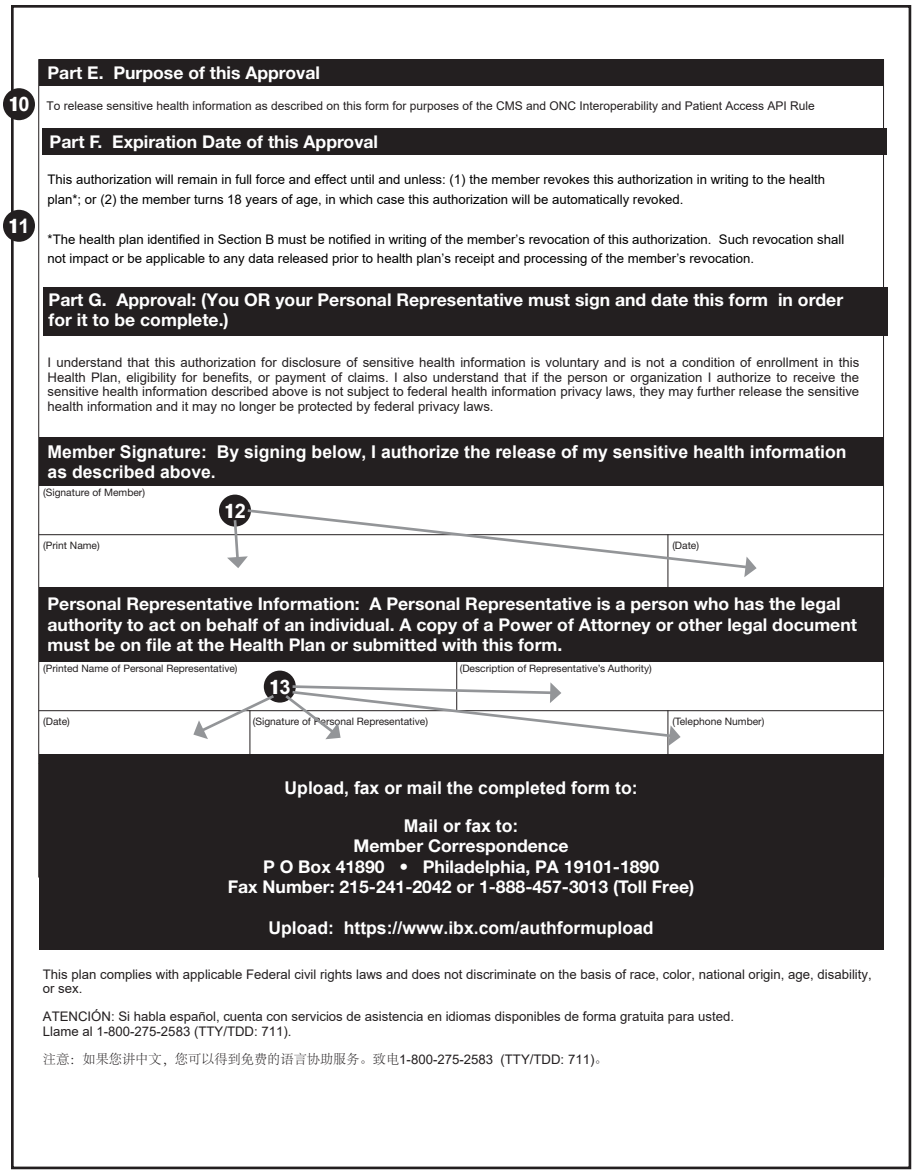
Part G. Approval

12 **Sign and print your name and put the date on the form.** Your name and signature must match the information in Part A.

13 **If you are signing this form on behalf of another person, or if you have Power of Attorney for health care, or are a legal guardian/conservator you must do the following:**

You must complete the Personal Representative Information section.

You must also provide us with a copy of the legal document showing that you are considered the personal representative of the member and include the document with this form.



Part E. Purpose of this Approval

10 To release sensitive health information as described on this form for purposes of the CMS and ONC Interoperability and Patient Access API Rule

Part F. Expiration Date of this Approval

This authorization will remain in full force and effect until and unless: (1) the member revokes this authorization in writing to the health plan*; or (2) the member turns 18 years of age, in which case this authorization will be automatically revoked.

11

*The health plan identified in Section B must be notified in writing of the member's revocation of this authorization. Such revocation shall not impact or be applicable to any data released prior to health plan's receipt and processing of the member's revocation.

Part G. Approval: (You OR your Personal Representative must sign and date this form in order for it to be complete.)

I understand that this authorization for disclosure of sensitive health information is voluntary and is not a condition of enrollment in this Health Plan, eligibility for benefits, or payment of claims. I also understand that if the person or organization I authorize to receive the sensitive health information described above is not subject to federal health information privacy laws, they may further release the sensitive health information and it may no longer be protected by federal privacy laws.

Member Signature: By signing below, I authorize the release of my sensitive health information as described above.

(Signature of Member) 12

(Print Name) (Date)

Personal Representative Information: A Personal Representative is a person who has the legal authority to act on behalf of an individual. A copy of a Power of Attorney or other legal document must be on file at the Health Plan or submitted with this form.

(Printed Name of Personal Representative) (Description of Representative's Authority) 13

(Date) (Signature of Personal Representative) (Telephone Number)

Upload, fax or mail the completed form to:

Mail or fax to:
Member Correspondence
P O Box 41890 • Philadelphia, PA 19101-1890
Fax Number: 215-241-2042 or 1-888-457-3013 (Toll Free)

Upload: https://www.ibx.com/authformupload

This plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY/TDD: 711).

注意：如果您讲中文，您可以得到免费的语言协助服务。致电1-800-275-2583 (TTY/TDD: 711)。

Examples of legal documents:

- **General or Durable Power of Attorney.** This document gives someone the legal power to act on your behalf and make health care decisions for you.
- **Legal Guardianship.** This is when the court appoints someone to care for another person.
- **Conservatorship.** This happens when a judge appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
- **Executor of estate or death certificate.** This type of document would be used when the person who is being represented has died.

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Authorization for Disclosure of Sensitive Health Information

Authorization for Disclosure of Sensitive Health Information

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Part A. Member Information: (individual whose information will be released)

Member First Name, Middle Initial and Last Name:		Member Identification Number (see identification card)	
Member Street Address:	City	State	Zip Code
Member Date of Birth:	Daytime Telephone Number (with area code)		

Part B. Health Plan: (organization that will release your information)

I authorize _____ to release my sensitive health information as described below.
(Health Plan Name)

Part C. Recipient: (person or organization that will receive your information)

The following individual or company has the right to receive my information (they must be 18 years of age or older).

First Name	Last Name
Company Name (if applicable)	
Address	Telephone Number
Relationship to Member in Part A	Date of Birth

Part D. Description of the Information to be Released:

Check whether member sensitive health information will be released to a third-party app or website through the Patient Access API for personal use or to your current health plan through the Payer to Payer Data Exchange. Please check only one box:

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- ☐ Alcohol/substance use disorder*
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted illness

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Part E. Purpose of this Approval

To release sensitive health information as described on this form for purposes of the CMS and ONC Interoperability and Patient Access API Rule.

Part F. Expiration Date of this Approval

This authorization will remain in full force and effect until and unless: (1) the member revokes this authorization in writing to the health plan*; or (2) the member turns 18 years of age, in which case this authorization will be automatically revoked.

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Part G. Approval: (You OR your Personal Representative must sign and date this form in order for it to be complete.)

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Member Signature: By signing below, I authorize the release of my sensitive health information as described above.

(Signature of Member)	
(Print Name)	(Date)

Personal Representative Information: A Personal Representative is a person who has the legal authority to act on behalf of an individual. A copy of a Power of Attorney or other legal document must be on file at the Health Plan or submitted with this form.

(Printed Name of Personal Representative)	(Description of Representative's Authority)	
(Date)	(Signature of Personal Representative)	(Telephone Number)

Upload, fax or mail the completed form to:

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Member Correspondence
P O Box 41890 • Philadelphia, PA 19101-1890
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Upload: https://www.ibx.com/authformupload

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ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY/TDD: 711).

注意：如果您讲中文，您可以得到免费的语言协助服务。致电1-800-275-2583 (TTY/TDD: 711

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al número telefónico de Servicio al Cliente que figura en el reverso de su tarjeta de identificación.

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。请致电您ID卡背面的客户服务电话号码.

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드 뒷면에 있는 고객 서비스 번호로 전화해 주십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para telefone do Atendimento ao Cliente que está no verso do seu cartão de identificação.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. કૃપયા તમારા આઇડી કાર્ડની પાછળ ગ્રાહક સેવા નંબર પર કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi số Dịch Vụ Chăm Sóc Khách Hàng ở mặt sau thẻ ID của bạn.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Позвоните в службу поддержки клиентов по номеру телефона, указанном на обратной стороне вашей идентификационной карты.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer Obsługi klienta znajdujący się na odwrocie Twojego identyfikatora.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiami il numero dell'Assistenza clienti che troverà sul retro della sua tessera identificativa.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية فإن خدمات المساعدة اللغوية متاحة لك بالمجان. الرجاء الاتصال برقم "خدمة العملاء" الموجود على ظهر بطاقة هويتك.

French Creole: ATANSYON : Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Tanpri rele nimewo Sèvis Kliyantèl ki sou do kat idantifikasyon ou a.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Mangyaring tawagan ang numero ng Customer Service na nasa likod ng iyong ID card.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Veuillez composer le numéro du service clientèle indiqué au dos de votre carte d'identité Médicale.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Number uff die hinnerscht Seit vun dei ID Card uff fer schwetze mit ebber as dich helfe kann.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कृपया अपने आईडी कार्ड के पीछे दिए ग्राहक सेवा नंबर पर कॉल करें।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Bitte rufen Sie unsere Kundendienstnummer auf der Rückseite Ihrer Identifikationskarte an.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。ご自分のIDカードの裏面に記載されているカスタマーサービスの番号へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می‌کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می‌باشد. لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی شما درج شده است تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh. T'áá shǫǫdí hódíílnih kojį'Áká'anídaalwo'jį éí binumber naaltsoos nitł'izgo nantinígíí bine'déé' bikáá'.

Urdu:
توجہ درکار ہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لیے مفت میں زبان معاون خدمات دستیاب ہیں۔ آپ کے شناختی کارڈ کے پیچھے دیئے گئے صارف خدمات نمبر پر براہ کرم کال کریں.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរសព្ទទៅលេខសេវាសមាជិក ដែលមាននៅផ្នែកខាងក្រោយនៃបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក ។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA, 19103; By phone: 1-888-377-3933 (TTY: 711), By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.