



## Authorization for Release of Health Information

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as an enrollee of VNS CHOICE Select, I understand that VNS CHOICE SELECT or its third party administrator is able to release or discuss my health information if an Authorization for Release of Health Information (hereinafter referred to as "Release") is on file. This Release will allow another person or an organization (including a spouse, family member, or friend, hereinafter referred to as "Recipient") to have access to my health information. My health information is any information that is maintained in the records of VNS CHOICE Select that relates to my past, present or future physical or mental health or medical condition, including any personal financial information. A separate Release must be completed for each Recipient.

This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV\* RELATED INFORMATION** only if I check the appropriate lines in Section 3 (below). In the event the health information described below includes any of these types of information, and I check the line(s) in Section 3, I specifically authorize release of such information to the person(s) indicated in Section 2.

If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

Please call Member Services at 1-866-783-1444 if you have questions about this form.

### Section 1 – Enrollee identification and contact information

The enrollee identified in this section is the person whose health information may be disclosed pursuant to this Release. Please provide your name and personal identification information, along with additional contact information in case we have any questions concerning this Release.

Name: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Health Plan Identification Number \_\_\_\_\_  
Daytime Telephone Number: \_\_\_\_\_  
Evening Telephone Number: \_\_\_\_\_

### Section 2 – Recipient information

VNS CHOICE Select or its Third Party Administrator (TMG Health) may release your health information to the following individual or organization. Please note that the individual named below is not permitted to modify the information in your records. Only a formally appointed personal representative (such as a Power of Attorney) has the authority to modify your health records.

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Daytime Telephone Number: \_\_\_\_\_  
Evening Telephone Number: \_\_\_\_\_  
Date of Birth (required, if Recipient is an individual): \_\_\_\_\_  
Health Plan Identification Number, if applicable: \_\_\_\_\_  
\_\_\_\_\_

\* Human Immunodeficiency Virus (the virus that causes AIDS). New York State Public Health Law protects information which could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

### Section 3 – Release limitations

VNS CHOICE Select may release your health information subject to the following limitations (check all that apply):

- Inquiry only (The person identified as the “recipient” above may receive all health information on file, but may not make changes to health information on file. Only a Personal Representative may make changes to the member’s record; see Section 5 below.)
- Primary Care Physician (“PCP”) updates only.
- Other limited access (please specify): \_\_\_\_\_
- Information relating to:  alcohol/drug treatment  
 mental health treatment (except psychotherapy notes)  
 confidential HIV\* related information

### Section 4 – Expiration and revocation

You may revoke this authorization at any time, except to the extent that action has already been taken based on this authorization, by notifying VNS CHOICE Select in writing. Such revocation will take effect once it is received by the VNS CHOICE Select and will not affect any use or disclosure of information before the revocation is received by the VNS CHOICE Select.

### Section 5 – Personal Representative

*(NOTE: If the person identified in Section 1 is signing this form, skip this section and go to section 6.)*

This Release may be completed and signed on behalf of any enrollee by the enrollee’s Personal Representative. A Personal Representative is a person who has **legal authority** to act in health care matters on your behalf, including a person who has been given a power of attorney, or a court-appointed guardian. Please attach the legal document that gives you the authority to act on behalf of the enrollee.

Name of Personal Representative: \_\_\_\_\_  
Relationship of Personal Representative to Enrollee or Subscriber: \_\_\_\_\_  
Personal Representative’s Daytime Telephone Number: \_\_\_\_\_  
Personal Representative’s Evening Telephone Number: \_\_\_\_\_

### Section 6 – Procedure to file or revoke this form

After completing and signing this form, please return it to the following address:

**VNS CHOICE Select**  
**Attention: Enrollment and Eligibility**  
**1250 Broadway, 3rd Floor**  
**New York, NY 10001**

To revoke this form, you may submit your request by fax or by mail to the address listed above. Please include your name, and health plan identification number in your correspondence. If applicable, please identify your status as a Personal Representative (see Section 5 above), as well as the name of the person who should no longer have access to your health information.

By signing where indicated below, you acknowledge your understanding that (i) this authorization is voluntary, (ii) the released health information may be re-disclosed, except as noted in Section 3 of this form, by the Recipient and may no longer be protected by federal privacy regulations if the Recipient is not a health plan, health care practitioner or other business covered by applicable privacy laws or regulations. Please keep a copy of this signed form for your files.

\_\_\_\_\_  
Signature of Enrollee or Enrollee’s Personal Representative

Date: \_\_\_\_\_

\_\_\_\_\_  
Printed name of Enrollee or Enrollee’s Personal Representative