AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Member Name: _____

Member ID: _____

As described in our Privacy Notice, Buckeye Health Plan is required by law to obtain your authorization for any use or disclosure of your health records for purposes other than your treatment, the payment for health care services provided to you and health care operations of Buckeye Health Plan. In our Privacy Notice, we provided you information about how Buckeye Health Plan can use or disclose your health records. You have a right to review and receive a copy of our Privacy Notice before signing this Authorization.

I _____, authorize the use and disclosure of my health information as described below:

1. This authorization applies to the following information:

_____

_____

_____

_____

2. I authorize the following persons (or class of persons) to receive my health information:	
Name:	
Title:	
Address:	
City/State/Zip	
Phone:	

3. We are requesting this authorization in order to use or disclose your health information for the following purposes:

_____

_____

_____

_____

☐ At the request of the individual.

4. This authorization expires: _____
(Date or Event)

You may request to inspect or copy the information that Buckeye Health Plan intends to disclose. You may refuse to sign this Authorization. Buckeye Health Plan will not condition treatment, payment, enrollment or eligibility for benefits on your providing or refusing to provide this Authorization. Once release of this health information is made to the above named person or persons, your health information may be subject to redisclosure by that person or persons. If you have authorized the disclosure of health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected.

You may revoke this authorization at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the address at the end of this form. You may deliver your revocation by any means you choose (e.g., personally or by mail), but it will be effective only when we actually receive it. Your revocation will not be effective to the extent that we or others have acted in reliance upon this Authorization.

If you are requesting information for yourself or for a third party, Buckeye Health Plan may assess appropriate and reasonable fees for the copying of such information. Such fees will comply with all state and federal laws.

AUTHORIZATION

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to Buckeye Health Plan. I understand that, by signing this form, I am confirming my authorization that Buckeye Health Plan may use and/or disclose to the persons and/or organizations named in this form the health information described in this form.

_____ _____
Signature of Member or Legal Representative Date

_____
Print Name

If signing on behalf of a Buckeye Health Plan health plan member please describe your authority and provide related documentation:

_____

_____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

For Buckeye Health Plan Use Only

Name: _____ **Title:** _____

Signature _____

REVOCATION

On _____/_____/_____ (DD/MM/YR), I signed an Authorization to release health information to:

I hereby revoke such Authorization effective immediately. I understand that the health information may already have been disclosed pursuant to and in reliance on my prior Authorization. I also understand that this revocation applies only to the information specifically described in the above-referenced document, and does not affect any prior executed Authorizations for other information.

If this revocation is limited (for example, you want us to stop disclosing some but not all of the information described above), please describe the limitations in the area below. If you leave this part blank, we will treat the revocation as complete.

Limitations:

Signature of Member or Legal Representative

Date

Print Name

If signing on behalf of a Buckeye Health Plan member please describe your authority and provide related documentation:

Your revocation will be effective once it is received at the following address:

Buckeye Health Plan
4349 Easton Way Suite 400
Columbus, OH 43219