Authorization to Disclose Protected Health Information

Instructions

Within this form, the terms "you" and "your" refer to the member or, if applicable, their parent/guardian or authorized representative. The terms "we", "our", and "us" refer to Healthcare Management Administrators (HMA), your third-party Health Plan administrator.

Please note the following:

- This authorization is valid for two years from the date of your signature.
- You may cancel this authorization at any time by sending written notice to the mailing address listed below.
- Cancellation of this authorization will not affect any actions taken by us before receiving your cancellation notice.
- Completing this authorization is not a condition to receive treatment, payment, enrollment or eligibility.
- We not responsible for any action taken by an authorized recipient of your protected health information.
- Once we discloses your information to an authorized recipient, the privacy protections provided by law may no longer apply.
- If you have coverage under more than one health plan administered by us, this authorization will apply to all of them.
- **Your PHI may contain sensitive data, including data related to treatment of sexually transmitted diseases, HIV/AIDS, mental health, reproduction or contraception (including prenatal care and abortion), gender dysphoria, gender affirming care, and domestic violence. If you want this information disclosed, please check the Sensitive Conditions box on page 2.**
- If you need to authorize disclosure of PHI to more persons/organization than there is room for in this form, please submit another form with their information.

Submission Information

Please provide the information in this form to us using one of the methods below (pick any option that works for you)**:**

Electronic Submission Options

✓ **Option 1: Fill out Online**:

1. Go to mi.accesshma.com and then go to **Download Member Forms**
2. Click on the DocuSign option under **Authorization to Disclose Protected Health Information**
3. Fill out and submit the form in DocuSign

✓ **Option 2: Fill out a PDF Form** (not recommended on mobile devices and in Internet browsers):

1. Go to mi.accesshma.com and then go to **Download Member Forms**
2. Click on the PDF option under **Authorization to Disclose Protected Health Information**
3. Fill out the form in compatible PDF software like Adobe Reader or Acrobat
4. Email your completed form to: PrivacyOffice@accesstpa.com

Paper Submission

✓ **Mail** the completed form to:
HMA
Attn: Privacy Office
PO Box 85016
Bellevue, WA 98015-5016

Authorization to Disclose Protected Health Information

Member Information

First Name _____ **Last Name** _____

Group ID Number[?] _____ **Member ID Number**[?] _____

[?] *This information can be located on your insurance ID card. "Member ID" is also called "Employee ID".*

Authorized Information to Disclose

Please select all that apply.

☐ Enrollment, eligibility, benefits ☐ Medical records and diagnosis ☐ Sensitive conditions[1] ☐ Appeals

☐ Claims, claim status, claim history ☐ COBRA premium and billing ☐ Pre-authorization

☐ Other (specify): _____

Purpose of Disclosure

Please select one.

○ To assist me with my health plan ○ Other (specify): _____

Authorized Parties

Within each column below, please list the person(s)/organization(s) to whom we can disclose your PHI.

Full Name			
Relationship			
Phone Number			
Mailing Address			

Attachments

If you are signing this authorization on behalf of the member listed above, please attach documentation demonstrating your authority to act on behalf of the individual, e.g. power of attorney, conservatorship, etc.

Signature

_____ _____ _____

Printed Name (First and Last) **Phone Number** **Relationship to Member (If you are the member, put "Self")**

_____ _____

Signature **Date**

By signing this Form you attest that 1) You are the member referenced herein, their parent/guardian, or are otherwise legally authorized to represent them; 2) The information listed herein is correct to the best of your knowledge; 3) You understand and acknowledge all stipulations listed herein.

[1] "Sensitive conditions" includes information about alcohol/substance abuse, which is protected information under Federal law (42 CFR Part 2). By checking this box, you're providing consent for us to disclose alcohol/substance abuse information to the authorized parties you designate in this form.