

UPMC for Kids™

A Product of UPMC Health Plan

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www.upmchealthplan.com/upmcforkids

UPMC for Kids™ Member Services: **1-800-650-8762**
TTY Services: **1-800-361-2629**

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Authorization to Use or Disclose Protected Health Information

INSTRUCTIONS

You have indicated that UPMC for Kids™ may use or disclose the protected health information (PHI) of your child or the child in your care. This is information that we have received, collected, or maintained in our files for certain purposes that, according to federal law, require your written permission to use or disclose. Please be advised that UPMC for Kids™ does not receive, collect, or maintain any medical records or hospital charts. You must contact your child's physician, dentist, or hospital for authorizations for these types of records.

Your child's privacy and rights are important to us. To ensure that your child's records are properly protected, we need you to tell us, in writing, the type of protected health information that you are authorizing us to use or disclose. Once you return this completed, signed, and dated form to us, we can verify the information and update our records. At that time we can use or disclose the protected health information for your child as you indicate on this form.

Please read this authorization form carefully and fill it out completely. Please print or type; if printing, please use a pen.

Member name: First _____ Last _____	UPMC for Kids™ member ID number (on the front of the child's ID card):	
Member address:	Date of birth:	Social Security number:
Name of person completing this form: First _____ Last _____	Best phone number to reach you in case we have questions:	
Relationship to UPMC for Kids™ member (please describe below):		

I, the parent or legal guardian of the member listed above, authorize UPMC for Kids™ to use or disclose my child's protected health information, as follows:

1 Information to Be Used or Disclosed

The type and amount of information to be used or disclosed is (please check off the appropriate items and/or write in any other specific records):

- | | | |
|--|--|--|
| <input type="checkbox"/> Behavioral health | <input type="checkbox"/> Medical/surgical claims information | <input type="checkbox"/> Pharmacy claims |
| <input type="checkbox"/> Chemical dependency claims | <input type="checkbox"/> Member complaint/grievance files | <input type="checkbox"/> Care management records |
| <input type="checkbox"/> Dental benefit claims | <input type="checkbox"/> Member services records | <input type="checkbox"/> Vision benefit claims |
| <input type="checkbox"/> Other records — please specify below: | | |

For the requested records checked above, please specify the doctor, dentist, hospital, facility, or other health care provider below. If applicable, specify the dates your child was seen, or a period of time, for the requested records.

2 Department Authorized to Make the Use or Disclosure

The UPMC *for Kids*™ staff person or department that is authorized to make the requested use or disclosure of my child's protected health information is:

If there is no specific person or department, please check: Member Services Department.

3 Person or Organization to Whom Disclosure Is to Be Made

I authorize disclosure of the above-indicated records to the following:

Name of person: _____ Telephone number: _____

Company/Organization: _____ Fax number: _____

Address: _____

4 Purpose of Use or Disclosure

The purpose of the requested use of disclosure is as follows:

If you prefer not to be specific, please check: At the request of the parent or legal guardian of the member.

5 Expiration of Authorization

Expiration date (or event) for the use or disclosure authorized in this form: _____

If no expiration date is indicated, UPMC *for Kids*™ will use a one-year period from the date indicated in number 10.

If this use or disclosure is for research purposes, please check one: No expiration date At end of research

6 Need to Renew Authorization

If I do not revoke this authorization, I understand that it will expire on the expiration date indicated in number 5 above. If I wish to extend the authorization, I must renew the authorization by completing a new authorization form.

7 Right to Revocation

I understand that I have the right to revoke this authorization at any time. I understand that to revoke this authorization I must do so in writing and submit my written revocation to the UPMC *for Kids*™ Member Services Department. I understand that this revocation will not apply to information that has already been released in response to my initial authorization.

8 Lack of Conditions

I understand that I do not need to sign this authorization form in order for my child to receive health care treatment, payment, enrollment in his or her health plan, or eligibility for health care benefits by UPMC *for Kids*™.

9 Risk of Disclosure to Persons Not Covered Under HIPAA Privacy Rules

I realize that the Health Insurance Portability & Accountability Act (HIPAA) Privacy Regulations are meant to ensure the privacy of my child's health information. I understand that once my child's protected health information (PHI) is disclosed according to my instructions on this form, if the information is disclosed to persons not subject to the federal HIPAA Privacy regulations, the information may be subject to re-disclosure by the recipient. The PHI disclosed may then no longer be protected by federal privacy regulations.

10 Right to Retain Copy of the Authorization

I understand that I have the right to retain or receive a copy of this authorization.

Please check if you are not making a copy of this authorization form for your own records and wish to receive a copy from UPMC *for Kids*™.

Name of parent or legal guardian: _____
(Please print)

Signature: _____ Date: _____

If this authorization is being submitted by the personal representative of the member, please provide signature:

Name of personal representative: _____
(Please print)

Signature: _____ Date: _____

Please return this completed form by mail to:

UPMC *for Kids*™
P.O. Box 2965
Pittsburgh, PA 15230-2965

Or by fax to:

412-454-7829

If you have any questions about this Member Authorization form, please call the UPMC *for Kids*™ Member Services Department at 1-800-650-8762. TTY users should call 1-800-361-2629.