Member Authorization to Use or Disclose Protected Health Information

Instructions

You have indicated that UPMC Health Plan may use or disclose your protected health information (PHI) that we have received, collected, or maintained in our files for certain purposes that, according to federal law, require your written permission.

Please be advised that UPMC Health Plan does **not** receive, collect, or maintain any medical records or hospital charts. You must contact your physicians or hospital for authorizations for these types of records.

Your privacy is important to us, as are your rights. In order to ensure that your records are properly protected, we need to have written confirmation of the details of your authorization for use or disclosure of your PHI.

Please take a moment to complete this authorization form. Once you return this completed, signed, and dated form to us, we can verify your information, adjust our records accordingly, and use or disclose the PHI that you have indicated.

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

Member Name:		
Member Address:		
Member ID Number:		
Date of Birth:	/ / /	
Phone Number:	( ) -	Please provide a telephone number. We may need to contact you about the information you have provided on this form.

I, the above-named member, authorize UPMC Health Plan to use or disclose my PHI, as follows:

1. Required Information

The type and amount of information that I am authorizing to be used or disclosed is:
(Please check the appropriate items and/or write in any other specific records, where indicated.)

- ❑ medical/surgical claims information
- ❑ pharmacy claims
- ❑ member complaint/grievance files
- ❑ other records (please specify):_____

Please specify the health care provider or facility where the care was rendered:	List the dates of service or time frame of requested records:

2. Department Authorized to Make the Use or Disclosure

The UPMC Health Plan staff person or department authorized to make the requested use or disclosure is:
(If there is no specific person or department, please write in "Member Services Department.")

_____

UPMC HEALTH PLAN

3. Person or Organization to Whom Disclosure Is to Be Made
I authorize disclosure of the above-indicated records to the following:

Name:				
Company/ Organization:				
Address:	Street:			
	City:		State:	
Telephone Number:	( ) -		ZIP:	
			Fax Number:	( ) -

4. Purpose of Use or Disclosure
The purpose of the requested use or disclosure is as follows:_____
(If you prefer not to be specific, please write in "at the request of the member.")

5. Expiration of Authorization
Expiration date (or event) for the use or disclosure authorized in this form is:_____
(If no expiration date is indicated, UPMC Health Plan will use the end of the current contract year for your health benefits. If this use or disclosure is for research purposes, please write in "none" or "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 #5 above. If I wish to extend the authorization, I must renew the authorization by completing a new authorization form.

7. Right to Revocation (revoke/cancel)
I understand that I have the right to revoke/cancel this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and submit my written revocation to the UPMC Health Plan 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 to receive health care treatment, payment, enrollment in my health plan, or eligibility for health care benefits by UPMC Health Plan.

9. Risk of Disclosure to Persons Not Covered Under HIPAA Privacy Rules
I realize that the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations are meant to ensure the privacy of my health information. I understand that once my 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, that the information may be subject to re-disclosure by the recipient. The PHI disclosed may then no longer be protected by federal privacy regulations. I understand that this is particularly important in the case of any disclosure of my PHI to my employer.

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 want to receive a copy from UPMC Health Plan.

(Required) **Member Signature**_____**Date**_____

Please note

a) In the event that the member is a minor or otherwise legally incompetent, please provide the name, address, and relationship to the member of the person who is signing the authorization form.

Name:_____ **Relationship:**_____

Address:_____ **Telephone Number:** ( ) -_____

City:_____ **State:**_____ **ZIP:**_____

b) If this authorization is being submitted by the personal representative of the member, please sign below.

Personal Representative (Please Print)_____

Personal Representative Signature_____ **Date**_____

Please return this completed form either by fax or by mail:

Fax to:
412-454-7829

Mail to:
UPMC Health Plan
PO Box 15230-2965
Pittsburgh, PA 15230-2965

If you have any questions about this Member Authorization form, please call the Member Services Department at the number on the back of your ID card.

The UPMC *for Life* HMO and PPO plans, the UPMC *for Life* Dual (HMO SNP) plan, and the UPMC *for Life* Options (HMO SNP) plan have contracts with Medicare. UPMC *for Life* Dual also has a contract with the Pennsylvania Medical Assistance (Medicaid) program. Enrollment in UPMC *for Life* depends on contract renewal. UPMC *for Life* and UPMC *for Life* Options are products of and operated by UPMC Health Plan Inc., UPMC Health Network Inc., and UPMC Health Benefits Inc. UPMC *for Life* Dual is a product of and operated by UPMC *for You* Inc.

UPMC Health Plan

U.S. Steel Tower, 600 Grant Street
Pittsburgh, PA 15219

www.upmchealthplan.com

AUTH TO USE DISCL H1 FORM 16MC0363 (RT) 12/9/16 xx xx

Nondiscrimination Notice

UPMC Health Plan[1] complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UPMC Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

UPMC Health Plan[1]:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Civil Rights Administrator.

If you believe that UPMC Health Plan[1] 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:

Civil Rights Administrator
UPMC Health Plan
600 Grant St., 55th Floor
Pittsburgh, PA 15219

Phone: 1-844-755-5611 (TTY: 1-800-361-2629)
Fax Number: 412-454-5964
Email: HealthPlanCompliance@upmc.edu.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Administrator 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.

[1]UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC *for You* Inc., and/or UPMC Benefit Management Services Inc.

Translation Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-539-3080 (TTY: 1-800-361-2629).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-539-3080（TTY：1-800-361-2629）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-539-3080 (TTY: 1-800-361-2629).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-539-3080 (телетайп: 1-800-361-2629).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-539-3080 (TTY: 1-800-361-2629).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-539-3080 (TTY: 1-800-361-2629) 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-539-3080 (TTY: 1-800-361-2629).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-539-3080 (رقم هاتف الصم والبكم: 1-800-361-2629).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-539-3080 (ATS: 1-800-361-2629).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-539-3080 (TTY: 1-800-361-2629).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-877-539-3080 (TTY: 1-800-361-2629).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-539-3080 (TTY: 1-800-361-2629).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-539-3080 (TTY: 1-800-361-2629).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-877-539-3080 (TTY: 1-800-361-2629)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-539-3080 (TTY: 1-800-361-2629).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-877-539-3080 (TTY: 1-800-361-2629).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-877-539-3080（TTY: 1-800-361-2629）まで、お電話にてご連絡ください。

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-877-539-3080 (TTY: 1-800-361-2629).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-877-539-3080 (телетайп: 1-800-361-2629).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-877-539-3080 (TTY: 1-800-361-2629).