

HIPAA Release Form

Use this form to receive information about the health or condition of a member/employee/patient.

Authorization for Release of Protected Health Information (PHI)



You may give **Piedmont Community Health Plan (PCHP)** written authorization to disclose your protected health information (PHI) to anyone that you designate and for any purpose. If you wish to authorize a person or receive your PHI, please complete the information below.

PART A: Member Information

Member First Name: _____ Member Last Name: _____ MI: _____
 Street Address: _____ City: _____ State: _____ Zip: _____
 Day Phone #: _ (____) _____ Date of Birth: ____/____/____ Member ID: _____
 mm dd yyyy

PART B: Persons or organizations authorized to receive PHI

The following people or companies are authorized to receive my PHI (they must be 18 years of age). You may also use this form to revoke a prior authorization by checking the "Revoke Prior Authorization" box.

1	Full Name: _____ Phone #: _ (____) _____ Relationship: _____ <input type="checkbox"/> Revoke Prior Authorization
2	Full Name: _____ Phone #: _ (____) _____ Relationship: _____ <input type="checkbox"/> Revoke Prior Authorization
3	Full Name: _____ Phone #: _ (____) _____ Relationship: _____ <input type="checkbox"/> Revoke Prior Authorization

PART C: Information to be released - Please check only one box

Full Disclosure – I understand that this authorization will allow PCHP and its affiliates to disclose my protected health information including but not limited to medical, pharmacy, dental, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable diseases, and other information. These records may have information on specific treatment or services and information created by others.

OR

Limited Disclosure – Only information specified below may be shared. (Ex. C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, AB, AC, AD, AE, AF, AG, AH, AI, AJ, AK, AL, AM, AN, AO, AP, AQ, AR, AS, AT, AU, AV, AW, AX, AY, AZ, BA, BB, BC, BD, BE, BF, BG, BH, BI, BJ, BK, BL, BM, BN, BO, BP, BQ, BR, BS, BT, BU, BV, BW, BX, BY, BZ, CA, CB, CC, CD, CE, CF, CG, CH, CI, CJ, CK, CL, CM, CN, CO, CP, CQ, CR, CS, CT, CU, CV, CW, CX, CY, CZ, DA, DB, DC, DD, DE, DF, DG, DH, DI, DJ, DK, DL, DM, DN, DO, DP, DQ, DR, DS, DT, DU, DV, DW, DX, DY, DZ, EA, EB, EC, ED, EE, EF, EG, EH, EI, EJ, EK, EL, EM, EN, EO, EP, EQ, ER, ES, ET, EU, EV, EW, EX, EY, EZ, FA, FB, FC, FD, FE, FF, FG, FH, FI, FJ, FK, FL, FM, FN, FO, FP, FQ, FR, FS, FT, FU, FV, FW, FX, FY, FZ, GA, GB, GC, GD, GE, GF, GG, GH, GI, GJ, GK, GL, GM, GN, GO, GP, GQ, GR, GS, GT, GU, GV, GW, GX, GY, GZ, HA, HB, HC, HD, HE, HF, HG, HH, HI, HJ, HK, HL, HM, HN, HO, HP, HQ, HR, HS, HT, HU, HV, HW, HX, HY, HZ, IA, IB, IC, ID, IE, IF, IG, IH, II, IJ, IK, IL, IM, IN, IO, IP, IQ, IR, IS, IT, IU, IV, IW, IX, IY, IZ, JA, JB, JC, JD, JE, JF, JG, JH, JI, JJ, JK, JL, JM, JN, JO, JP, JQ, JR, JS, JT, JU, JV, JW, JX, JY, JZ, KA, KB, KC, KD, KE, KF, KG, KH, KI, KJ, KK, KL, KM, KN, KO, KP, KQ, KR, KS, KT, KU, KV, KW, KX, KY, KZ, LA, LB, LC, LD, LE, LF, LG, LH, LI, LJ, LK, LL, LM, LN, LO, LP, LQ, LR, LS, LT, LU, LV, LW, LX, LY, LZ, MA, MB, MC, MD, ME, MF, MG, MH, MI, MJ, MK, ML, MM, MN, MO, MP, MQ, MR, MS, MT, MU, MV, MW, MX, MY, MZ, NA, NB, NC, ND, NE, NF, NG, NH, NI, NJ, NK, NL, NM, NN, NO, NP, NQ, NR, NS, NT, NU, NV, NW, NX, NY, NZ, OA, OB, OC, OD, OE, OF, OG, OH, OI, OJ, OK, OL, OM, ON, OO, OP, OQ, OR, OS, OT, OU, OV, OW, OX, OY, OZ, PA, PB, PC, PD, PE, PF, PG, PH, PI, PJ, PK, PL, PM, PN, PO, PP, PQ, PR, PS, PT, PU, PV, PW, PX, PY, PZ, QA, QB, QC, QD, QE, QF, QG, QH, QI, QJ, QK, QL, QM, QN, QO, QP, QQ, QR, QS, QT, QU, QV, QW, QX, QY, QZ, RA, RB, RC, RD, RE, RF, RG, RH, RI, RJ, RK, RL, RM, RN, RO, RP, RQ, RR, RS, RT, RU, RV, RW, RX, RY, RZ, SA, SB, SC, SD, SE, SF, SG, SH, SI, SJ, SK, SL, SM, SN, SO, SP, SQ, SR, SS, ST, SU, SV, SW, SX, SY, SZ, TA, TB, TC, TD, TE, TF, TG, TH, TI, TJ, TK, TL, TM, TN, TO, TP, TQ, TR, TS, TT, TU, TV, TW, TX, TY, TZ, UA, UB, UC, UD, UE, UF, UG, UH, UI, UJ, UK, UL, UM, UN, UO, UP, UQ, UR, US, UT, UY, UZ, VA, VB, VC, VD, VE, VF, VG, VH, VI, VJ, VK, VL, VM, VN, VO, VP, VQ, VR, VS, VT, VU, VV, VW, VX, VY, VZ, WA, WB, WC, WD, WE, WF, WG, WH, WI, WJ, WK, WL, WM, WN, WO, WP, WQ, WR, WS, WT, WU, WV, WW, WX, WY, WZ, XA, XB, XC, XD, XE, XF, XG, XH, XI, XJ, XK, XL, XM, XN, XO, XP, XQ, XR, XS, XT, XU, XV, XW, XX, XY, XZ, YA, YB, YC, YD, YE, YF, YG, YH, YI, YJ, YK, YL, YM, YN, YO, YP, YQ, YR, YS, YT, YU, YV, YW, YX, YY, YZ, ZA, ZB, ZC, ZD, ZE, ZF, ZG, ZH, ZI, ZJ, ZK, ZL, ZM, ZN, ZO, ZP, ZQ, ZR, ZS, ZT, ZU, ZV, ZW, ZX, ZY, ZZ)

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PART D: Purpose of this approval - Please check only one box
 To give out information as shown on this form, OR
 For this reason: _____

PART E: Date your approval expires - Please check only one box
 I would like this authorization to expire: One year after date of signature in Part F Upon my death
 Upon my request to revoke the authorization On (specify date or event): _____
If no date or event is specified, authorization will expire one year after the date of signature in Part F.

PART F: Review and approval
 I understand the following:
 • I have a right to revoke this authorization at any time. My revocation is not effective until delivered in writing and is not effective as to health records already disclosed under this authorization.
 • The information released in response to this authorization may be redisclosed by a recipient and may no longer be protected to the same extent as was protected while in the possession of PCHP.
 • My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
 Member or Legal Representative Signature: _____ Date: _____

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please complete the following:
 Legal Representative Name: _____
 Street Address: _____
 Legal Relationship to Member: _____ City: _____ Phone #: _ (____) _____
 State: _____ Zip: _____

Please submit either a copy of a healthcare, general or Durable Power of Attorney, or a court order/other legal documentation that shows custody or authority of the legal representative to act on the members' behalf.

Please return completed form to:
 Piedmont Community Health Plan • 2316 Atherholt Road • Lynchburg, VA 24501
 Fax: 434-947-3670 Attn: Customer Service
 Email: Customer.service@pchp.net


Piedmont Community Health Plan complies with applicable Federal civil rights laws, and does not discriminate on the basis of race, color, national origin, age, disability, or sex in health programs and activities. We provide free services to help you communicate with us, such as large print, or you can ask for an interpreter. To ask for help, please call our toll-free phone number 1-800-400-7247, Option 2 (TTY: 711).
 Español (Spanish) ATENCION: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-400-7247 (TTY: 711).
 한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-400-7247 (TTY: 711) 번으로 전화해 주십시오.

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To access, click [here](#) and select HIPAA Release form, or visit [PCHP.net](#), select Group Coverage, Member, Member Forms, HIPAA Release form.

Appointment of Representative Form

Use this form to take action (e.g., file an appeal) on behalf of a member/employee/patient.



PIEDMONT
COMMUNITY HEALTH PLAN

APPOINTMENT OF REPRESENTATIVE

Name of Party	Member Number:
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Section 1: Representative
To be completed by the party seeking representation

I appoint this individual, _____ to act as my representative in connection with my coverage with Piedmont Community Health Plan and related provisions of evidence of coverage. I authorize this individual to make any request; to present or to elicit evidence; to obtain grievance/appeals information; and to receive any notice in connection with my grievance/appeal, wholly in my stead. I understand that personal medical information related to my grievance/appeal may be disclosed to the representative indicated below.

Member Signature	Date	
Street Address	Phone Number (with Area Code)	
City	State	Zip Code

Section 2: Acceptance of Appointment
To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Virginia Department of Health or Virginia Bureau of Insurance that I am not disqualified from acting as the party's representative.

I am a/an _____
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative	Date	
Street Address	Phone Number (with Area Code)	
City	State	Zip Code
Signature	Date	

Piedmont Community Health Plan • 2316 Atherholt Rd., Lynchburg, VA 24501

To access, click [here](#) and select Appointment of Representative form, or visit [PCHP.net](#), select Group Coverage, Member, Member Forms, Appointment of Representative Form.