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 h
information (PHI) to anyone that you designate and for any purpose. If you wish to authorize a person or e
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 ag
You may also use this form to revoke a prior authorization by checking the "Revoke Prior Authori

1	Full Name: ____________________ Relationship: ____________________	Phone #: _(____)_ ☐ Revoke Prior Autho
2	Full Name: ____________________ Relationship: ____________________	Phone #: _(____) ☐ Revoke Prior Aut
3	Full Name: ____________________ Relationship: ____________________	Phone #: _(_ ☐ Revoke Prior A

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

☐ Full Disclosure – I understand that this authorization will allow PCHP and its affili
protected health information including but not limited to medical, pharmacy, de
substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable diseas
information. These records may have information on specific treatment or serv
information created by others.

OR

☐ Limited Disclosure – **Only** information specified below may be shared. (Ex. C
information, a specific date range, or product type.)

____

PCHP.HIPAA.Auth (Rev. 12.12.2022)

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: ____________________ City: ______________ State: ______Zip: ______
Legal Relationship to Member: ____________________ Phone #: _(____) ___________

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) ATENCIÓN: 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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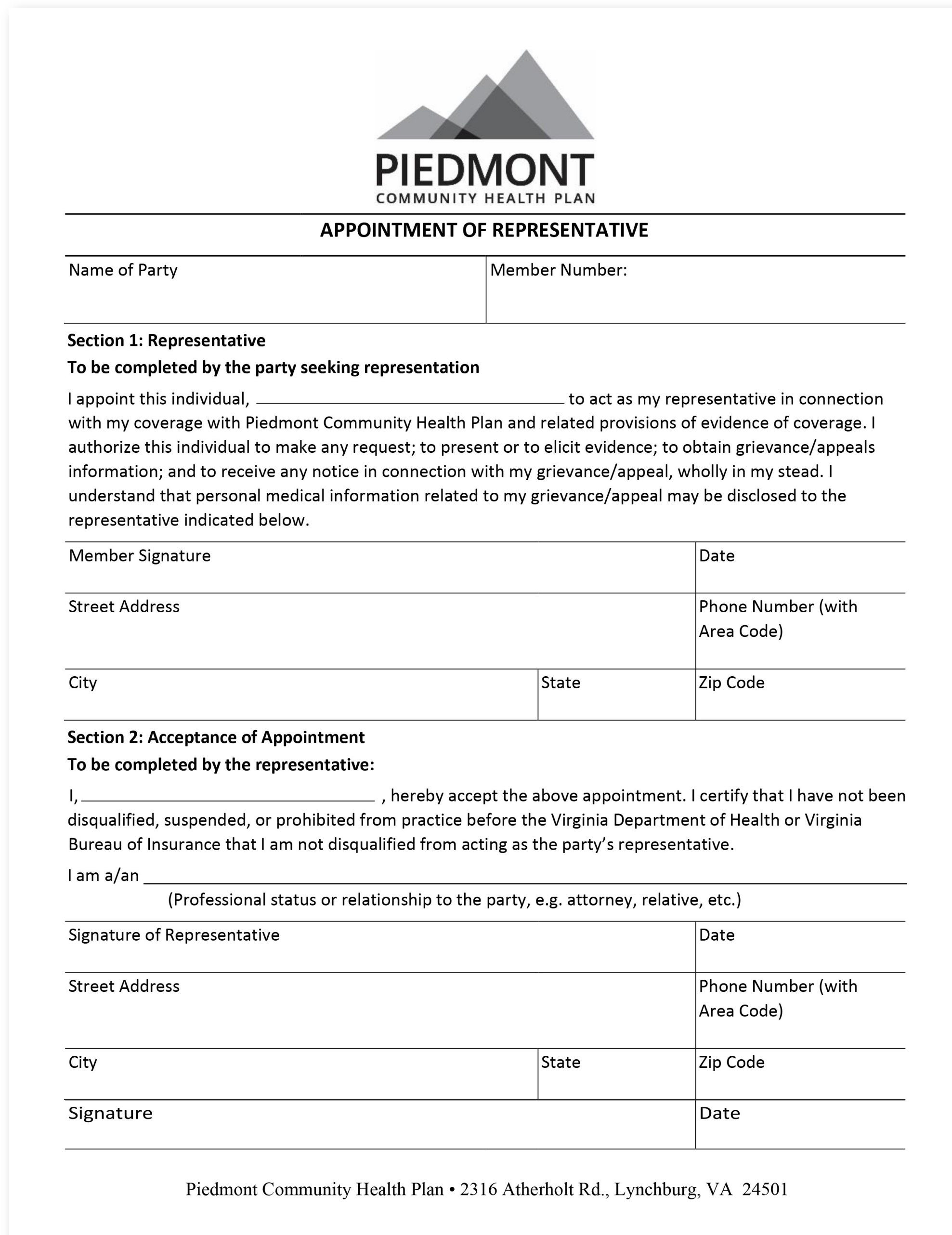
To access, click here and select HIPAA Release form, or visit PCHP.net, select Group Coverage, Member, Member Forms, HIPAA Release form.

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:

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

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