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 entity to receive your PHI, please complete the information below. If you wish to authorize a person or entity to take action (such as file an appeal) with Piedmont or to speak to Piedmont on your behalf, please complete an Appointment of Representative Form.

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 or older).

You may also use this form to revoke a prior authorization by checking the "Revoke Prior Authorization" box.

1	Full Name: ____ Phone #: _______________________ Relationship: ____ ☐ Revoke Prior Authorization (see Part F)
2	Full Name: ____ Phone #: _______________________ Relationship: ____ ☐ Revoke Prior Authorization (see Part F)
3	Full Name: ____ Phone #: _______________________ Relationship: ____ ☐ Revoke Prior Authorization (see Part F)

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 use or give out protected health information including but not limited to medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and healthcare program information. These records may have information on specific treatment or services I have received, and information created by others.

OR

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

____

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: ____ Phone #: ___________________

Street Address: _________________________________ City: _________________ State: _______Zip: ________

Legal Relationship to Member: ____

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 • 1920 Atherholt Road • Lynchburg, VA 24501
Fax: 434-947-3670 Attn: Customer Service
Email: clerical@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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