UnitedHealthcare®
A UnitedHealth Group Company

**Neighborhood Health Partnership**

## AUTHORIZATION TO RELEASE INFORMATION - One year or as specified

Note: Your enrollment in a health plan, eligibility for benefits, processing and payment of claims, or treatment is not conditioned upon giving this Authorization.

Member Name: ______________________________________________________________________________________

ID# (Number on ID card):_____________________________________________________________________________

Date of Birth: _____ / _____ / ________ S.S.N.: _______ -_____- ________ Phone: _______ - _______ - ________

Evening Phone: ________ – ________ – ______________ Email Address:______________________________________________

Address: _____________________________________________________________________________________________

City: ____________________________________________________________ State:___________ Zip: ______________________

**AUTHORIZATION TO RELEASE AND DISCLOSE INFORMATION & RECORDS**

I authorize the release and disclosure of information or records as follows:
I authorize Neighborhood Health Partnership and any of its subsidiaries ("UnitedHealthcare") to release, disclose, or deliver the information or records described below to: ___________________________________________________________________________________________

whose address is: ________________________________________________________________________________________

City: ____________________________________________________________ State:___________ Zip: ______________________

**DATES OF THE INFORMATION OR RECORDS THAT MAY BE RELEASED**

The dates of the information or records I hereby authorize to be released, disclosed, or delivered are (complete by placing a check mark on the appropriate line):
____ All dates of service or anything related to all dates of service
____ The following dates of service or anything related to the following dates of service: ____ / ____ / _______ – ____ / ____ / _______

**METHOD OF DISCLOSURE**

The method of disclosure is (complete by placing a check mark on the appropriate line):
____ Discussions with Neighborhood Health Partnership staff (only)
____ Discussions with Neighborhood Health Partnership staff and, if necessary, paper copies mailed
____ Paper copies (only) mailed upon processing this Authorization and upon any subsequent request
____ Web access (only) member must be on existing account as either subscriber or active member Relationship:___________________

**PURPOSE OF THE DISCLOSURE**

The purpose for this Authorization is (complete by placing a check mark on the appropriate line):
____ To provide information or records to the person or entity named above at my request, or
____ Please explain other purpose: ________________________________________________________________________________

**EXPIRATION DATE OF AUTHORIZATION**

Neighborhood Health Partnership is authorized to release, disclose, or deliver the specified information or records for one year after the signature date set forth below. If an earlier expiration date is preferred, specify the earlier expiration date: ____ / ____ / _______ . (If member is a minor, the Authorization expires on the member's 18th birthday, if earlier than the above expiration date.)

By my signature below, I specifically authorize Neighborhood Health Partnership to release, disclose, and deliver the above-specified information or records in its possession to the above-specified person or entity, which may include confidential information or records pertaining to mental health treatment (excluding mental health therapist notes), substance abuse treatment, HIV-related information, genetic testing information, and any other information or records afforded confidential treatment by federal and/or state law.

**I SPECIFICALLY AUTHORIZE AND CONSENT TO THIS DISCLOSURE AND I HAVE READ THE FRONT AND BACK OF THIS AUTHORIZATION.**

Signature:___________________________________________________________________________ Date:____ / ____ / 20_____

**OR INSTEAD**

If this request is authorized by a parent/guardian on behalf of a minor child or by a legal representative, please complete the following instead of the above signature:
Signature of parent, guardian, or legal representative:_____________________________________________ Date:____ / ____ / 20_____

Printed name of parent, guardian, or legal representative:_______________________________ Daytime phone:_____-_____-________

Age of minor:_____ Relationship to member or authority to act on member's behalf: __________________________________________

(If this request is made by a legal representative on behalf of the member, a copy of the legal representative's authority or Power of Attorney must be attached if it is not already on file with Neighborhood Health Partnership.)

**PLEASE MAINTAIN A COPY OF THIS AUTHORIZATION**

…………………………………………………………………………………………………………………………………………………....

For Neighborhood Health Partnership purposes only
Sent by:_____________________________________________ Date:____ / ____ / 20_____ Location:____________________

## NOTICES AND ACKNOWLEDGEMENTS

**REVOCATION RIGHT**: I understand that I have a right to revoke this Authorization in writing at any time. Any revocation must be delivered to the individual or organization listed below. I understand that the revocation will be effective only after Neighborhood Health Partnership's receipt and processing of it, except to the extent Neighborhood Health Partnership has taken steps in reliance upon this Authorization before receipt of the written revocation.

Please send revocations to:
**Neighborhood Health Partnership**
**P. O. Box 5210**
**Kingston, NY 12402-5210**

**RE-DISCLOSURE NOTICE**: I understand that information or records disclosed pursuant to this Authorization may be re-disclosed by the recipient and will no longer be protected by federal law, unless the recipient is a covered entity under federal privacy regulations or has signed an agreement with Neighborhood Health Partnership as a Business Associate, pursuant to federal privacy regulations.

**ACKNOWLEDGEMENT OF RECEIPT OF COPY OF AUTHORIZATION**: I acknowledge that I have received a copy of this Authorization.

**CHARGES**: Neighborhood Health Partnership reserves the right to charge, as permitted by law, for the information or records produced pursuant to this Authorization. I agree to pay these charges.

**COPY AS ORIGINAL**: I understand that a copy or facsimile (fax) is valid as an original.

## FEDERAL AND/OR STATE LAWS AND RE-DISCLOSURE

If my information or records contain information regarding mental health treatment, substance abuse treatment, or HIV-related information, I understand that such information or records may be protected under federal and/or state law. Federal regulations require any disclosure or re-disclosure of such information or records to be accompanied by the following statement:

> This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Applicable law may provide me with a right to inspect any such records released, disclosed, or delivered pursuant to this Authorization at any time.

State and/or federal law provide that I may have a right to prohibit re-disclosure of confidential medical information or records and further disclosure may not occur without my express written permission, except:

- if litigation/arbitration is involved, the recipient may, without further authorization, re-disclose any and all information or records released or disclosed to parties, their legal counsel, experts or potential experts, insurers, my health care providers, anyone against whom I have made a claim, administrative agencies, the court or arbitration service and its personnel and officers, any person authorized by law or the court or arbitrator (including but not limited to persons attending proceedings), and any agents or employees of said persons.
- upon other occasions as permitted by law.