Keystone First
200 Stevens Drive
Philadelphia, PA 19113

Keystone First

Tips to complete the authorization to disclose (share) your protected health information form

You may authorize us to share information about your health or plan benefits with someone else. To do this, you will need to fill out the Authorization for Disclosure of Health Information form.

Important information about this form

By signing this form, you allow us to share your protected health information (PHI) with the persons and organizations you put on this form. Sharing your PHI may identify you to others. For your PHI to be shared with anyone else, you must give your consent, unless otherwise permitted by law.

To allow us to share your PHI, please fill out the form completely. You will find helpful tips for filling out this form on the next page.

When you are done, send the completed form back to us. You can mail it to:

Keystone First
Consent Processing Center
P.O. Box 7092
London, KY 40742-7092

If you have any questions about this letter or the enclosed form, we can help. Call Member Services at **1-800-521-6860 (TTY 1-800-684-5505)**.

Keystone First

Helpful tips for completing the form.

Please fill in as much information as you can.

Section A

- Enter the member's information here.

Section B

- Enter the information for the person or organization that can get the member's PHI.
- If you want the person or organizations you put in this section to also share your information with Keystone First, check the Yes box. You must check either Yes or No.

Section C

- Tell us what type of information we can share with the person(s) or organizations listed in section B. You have choices:
  - Check "Entire Record" to ask us to share all of your information.
  - Check "Special Records" which gives specific permission to share certain PHI.
  - Check "only limited information" describe the information you want shared.

Section D

- Check the boxes for the reasons why you would like your information shared.
- You must check at least 1 box.

Section E

- Tell us when you would like the form to expire (no longer be in effect).
  - Check the first box to have the form expire 1 year after your coverage with Keystone First ends.
    Or
  - Check the second box and write in a date or event.

Section F

- Read this section to understand your rights about this form.
- Sign the form.
- The form must be signed by the member, parent/guardian or legal representative.
- If you are the legal representative then you must complete the personal representative information and attach the legal documents.

Addendum to Authorization for Disclosure of Health Information

- This section is only to be filled out if the member is **physically unable** to sign the form.
- This section must be signed by 2 witnesses to show that:
  - The information on the form was communicated to the member.
  - The member understands the information in the form.
  - The member freely gave their consent to have their PHI shared.

Authorization for Sharing Health Information

[Please print]

Keystone First

Coverage by Vista Health Plan,
an independent licensee of the Blue Cross and Blue Shield Association.

This form is used to share your protected health information ("PHI") where required by federal and state privacy laws. Your authorization allows Keystone First to share your PHI with the person(s) or organization(s) that you choose. You can also choose to allow the person(s) or organization(s) to share your PHI with Keystone First. You can cancel this authorization at any time by submitting a request to Keystone First. Contact Member Services at 1-800-521-6860 (TTY: 1-800-684-5505) for further instructions.

Part A. Member Information: (individual whose PHI will be shared)

Member First Name:		Middle Initial:
Last Name:	Member ID (see ID card):	
Member Street Address:		
City:	State:	ZIP code:
Member Date of Birth:	Daytime Telephone Number (with area code):	

Part B. Recipient: (person or organization that will receive your PHI)

The following individual or organization has the right to receive my PHI:

Do you want the following individual or organization to also share your PHI with us? ☐ Yes ☐ No

First Name:	Last Name:	
Organization Name (if applicable)		
Address:		
City:	State:	ZIP code:
Telephone Number (with area code):		
Relationship to Member in Part A:		

Part C. Description of the PHI to be Shared:

Tell us what types of PHI can be shared. You can check as many boxes as you want. At least one box must be selected.

☐ **Entire record.** All PHI related to the provision of and payment for my health care benefits and services. Federal law requires a separate authorization to share psychotherapy notes.

☐ **Special records. <u>Some laws require you to give specific permission to share certain PHI. Please check the boxes below for PHI that is OK to share</u>.** By checking these boxes, you give permission for all your records containing that type of PHI to be shared. If you only want to authorize sharing of a subset of records, such as records about only one diagnosis, fill out the "Only limited information" section below.

- ☐ Genetic information
- ☐ HIV/AIDS
- ☐ Substance or alcohol use
- ☐ Mental/behavioral health (including inpatient treatment)
- ☐ Sexually transmitted disease
- ☐ Abortion and family planning
- ☐ Communicable diseases
- ☐ Information you have asked us to treat confidentially

☐ **Only limited information.** In the box below, describe the PHI you want shared. Examples:

- The claim related to my service on [date].
- Appeal information related to my claim on [date].

Please describe the information you want shared:

Part D. Purpose of this Authorization

This authorization is valid for sharing of PHI for the following purposes. (Please check one or both boxes.)

☐ To help diagnose, treat, manage and/or pay for my health needs.

OR

☐ For the following reason:

This authorization shall be invalid if used for any purpose other than the purpose(s) stated above.

Part E. Expiration Date of this Authorization

This authorization will expire. (Please check one box.)

☐ I want the authorization to expire one (1) year after my coverage with Keystone First ends. (See information below)*

OR

☐ Upon the following date, event or condition*:

* Keystone First must be notified of the event/condition to cancel this authorization. In North Carolina and New Jersey, this authorization automatically expires one year after the date it was signed, unless you choose an earlier date. In New Hampshire, the authorization automatically expires two years after the date it was signed, unless you choose an earlier date. In Louisiana, if you are requesting the sharing of genetic information, the authorization expires sixty days after the date it was signed, unless you choose an earlier date. In the District of Columbia, if you are requesting the sharing of mental health information, the authorization automatically expires one year after the date it was signed, unless you choose an earlier date.

Part F. Approval: (You OR your Personal Representative must sign and date this form in order for it to be complete.)

I understand that this authorization for sharing my PHI is voluntary and is not a condition of enrollment in Keystone First, eligibility for benefits, or payment of claims. I understand that I may cancel this authorization at any time by submitting a request to Keystone First, and that cancelling this authorization will not affect any action taken pursuant to the authorization prior to my request to cancel. I also understand that if I cancel this authorization, I should separately notify the individual(s) or organization(s) listed in Part B above if I wish for those individual(s) or organization(s) to no longer share my PHI. I also understand that if the person or organization I authorize to receive my PHI described above is not subject to federal or state health information privacy laws, they may further share my PHI and it may no longer be protected by federal or state privacy laws. I also understand that I or my personal representative have a right to receive a copy of this form and to review my PHI that may be shared because of this authorization.

Member Signature: By signing below, I authorize the sharing of my PHI as described above.	
Signature of Member:	Date:

Personal Representative Information: By signing below, I authorize the sharing of PHI of the member as described above. (A Personal Representative is a person who has the legal authority to act on behalf of an individual. A copy of a Power of Attorney or other legal document must be on file at Keystone First or submitted with this form.)	
Printed Name of Personal Representative:	
Address of Representative:	
Description of Personal Representative's Authority:	
Signature of Personal Representative:	
Date:	Telephone Number:

Return the Completed Form to: Consent Processing Center, P.O. Box 7092, London, KY 40742-7092
Fax Number: 1-833-214-2242 (Toll Free)

Addendum to Authorization for Disclosure of Health Information

Verbal consent

We, the undersigned, attest that the member identified in Section A above is **physically unable** to sign this authorization. Verbal consent does not replace the need for documentation showing that another person is the member's personal representative, and cannot replace this documentation simply because it is inconvenient for the member to sign.

Reason:

The signatures below indicate:

- The information on this form was communicated to the member.
- The member indicated their understanding of the information in this authorization.
- The member freely gave their consent.

Method of communication to member:

☐ Phone

☐ In person

☐ Other (specify):

Witness printed name:	Witness printed name:
Witness signature:	Witness signature:
Date: / /	Date: / /

Keystone First

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Nondiscrimination Notice

Keystone First complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

Keystone First does not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

Keystone First 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)

Keystone First 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 **Keystone First** at **1-800-521-6860** (TTY **1-800-684-5505**).

If you believe that **Keystone First** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation, you can file a complaint with:

Keystone First,
Member Complaints Department,
Attention: Member Advocate,
200 Stevens Drive
Philadelphia, PA 19113-1570
Phone: **1-800-521-6860**, TTY **1-800-684-5505**,
Fax: **215-937-5367**, or
Email: PAmemberappeals@amerihealthcaritas.com

The Bureau of Equal Opportunity,
Room 223, Health and Welfare Building,
P.O. Box 2675,
Harrisburg, PA 17105-2675,
Phone: **(717) 787-1127**, TTY/PA Relay **711**,
Fax: **(717) 772-4366**, or
Email: RA-PWBEOAO@pa.gov

You can file a complaint in person or by mail, fax, or email. If you need help filing a complaint, Keystone First and the Bureau of Equal Opportunity are 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 S.W.,
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**.

Nondiscrimination Notice

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.
Call: **1-800-521-6860 (TTY: 1-800-684-5505)**.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-521-6860 (TTY: 1-800-684-5505)**.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-521-6860 (телетайп: 1-800-684-5505)**.

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 **1-800-521-6860 (TTY : 1-800-684-5505)**。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-521-6860 (TTY: 1-800-684-5505)**.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-521-6860** (رقم هاتف الصم والبكم: **1-800-684-5505**).

ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् **1-800-521-6860 (टिटिवाइ: 1-800-684-5505)** ।

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-521-6860 (TTY: 1-800-684-5505)** 번으로 전화해 주십시오.

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-800-521-6860 (TTY: 1-800-684-5505)**។

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le **1-800-521-6860 (ATS : 1-800-684-5505)**.

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် **1-800-521-6860 (TTY: 1-800-684-5505)** သို့ ခေါ်ဆိုပါ။

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-521-6860 (TTY: 1-800-684-5505)**.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-521-6860 (TTY: 1-800-684-5505)**.

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-800-521-6860 (TTY: 1-800-684-5505)**।

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në **1-800-521-6860 (TTY: 1-800-684-5505)**.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-521-6860 (TTY: 1-800-684-5505)**.