

Authorization for Use or Disclosure of Medical Information (Designated Agent)

Read this information first:

You should complete this form if you wish to authorize Optima Health to use or disclose your medical information to persons who may or may not directly be involved in making decisions regarding your health care. This authorization will remain in effect until the (a) date you specify; (b) two (2) years from the date signed; or (c) the date you withdraw your permission.

*****Mail this form to: Optima Health, 4417 Corporation Lane, Virginia Beach, VA 23462.**

Step 1: Complete the demographic information for the person receiving services:

1. _____ 2. ____/____/____
Name Date of Birth
3. _____
Member ID # or SSN #

Step 2: Tell us what medical information may be used or disclosed:

4. Check the appropriate box to indicate what information may be used/disclosed or changed:
Claims information PCP Address Change/correct account information
Other (see instructions) _____
5. Check the appropriate box to indicate the purpose of the use or disclosure:
a. At my request
b. Other (see instructions) _____

Step 3: Tell us whom you are authorizing to use or receive your medical information:

6. _____ 8. **OPTIONAL: Authorization**
Name of Authorized Person termination date:
____/____/____
7. _____
Address of Authorized Person

Step 4: Complete your acknowledgement that you understand that:

- You have the right to review the information that is being used or disclosed;
- You do not have to complete this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits;
- The information used or disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by the federal privacy laws;
- You have a right to revoke this authorization at any time by completing and sending to Optima Health a "Revocation of Authorization" Form and
- You have a right to receive a copy of this signed authorization.

9. _____
Person receiving services or Designated Representative's signature** Date
10. _____
Designated Representative's relationship **

****Attach a copy of the appropriate legal document granting authority**

INSTRUCTIONS FOR AUTHORIZATION COMPLETION

1. Please **PRINT** information in pen so it is easy to read.
2. Do not skip any steps. Fill all information in as completely as possible.
3. Step 2, #4: information to be disclosed/changed (Other): use specific descriptions such as:

Claims information from _____ to _____
Clinical information from _____ to _____
Designated Record Set from _____ to _____
Appeal/review information from _____ to _____
All claims information
All clinical information
Complete Designated Record Set
All appeal/review information
Change PCP
Change or make corrections to address, phone, account information, etc.

4. Step 2, #5: purpose for the disclosure (other) use specific description such as:

Coordination of care/case management
Appeal or grievance resolution
Eligibility or enrollment determination
Evaluation of fitness for duty
Resolution on a Disability claim
Resolution of a Workers' Comp claim
Treatment and follow-up
Research
Marketing
Legal, i.e., subpoena

5. You must sign and date #9

QUESTIONS: Call Member Services for any questions or concerns regarding this authorization form.