OptimaHealth

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 and/or 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. _____
Name of Authorized Person

7. _____
Address of Authorized Person

8. OPTIONAL: Authorization termination date: ___ ___/___ ___/___ ___ ___ ___

Step 4: Complete and sign this authorization for alcohol and/or drug abuse records:

I acknowledge that information to be used or disclosed as a result of this Authorization may include records that are protected by other federal and/or state laws applicable to substance abuse. I SPECIFICALLY AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION RELATING TO DRUG AND/OR ALCOHOL ABUSE. The recipient of drug and/or alcohol abuse information disclosed as a result of this Authorization will need my further written authorization to re-disclose this information. 42 CFR §2.32 restricts any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

9. _____ **___ ___/___ ___/___ ___ ___ ___**
Person receiving services or Designated Representative's signature** **Month Day Year**

10. _____ **___ ___/___ ___/___ ___ ___ ___**
Parent/Guardian Signature (if required by State Law) **Month Day Year**

Step 5: 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.**

11. _____ **___ ___/___ ___/___ ___ ___ ___**
Person receiving services or Designated Representative's signature** **Month Day Year**

12. _____ **___ ___/___ ___/___ ___ ___ ___**
Designated Representative's relationship **Month Day Year**

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

OptimaHealth

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. Step1, #1, #2, & #3: This is **your** name, date of birth, your social security number or your Optima member number.

4. Step 2, #4: This is the information you want Optima to provide. The "other" section allows you to write in a specific description of the medical information or name of the documents not on the checklist. Example: 'Claims for Dr. Smith from 2/1/09 to 2/1/10'.

5. Step 2, #5: This is a description of the purpose for requesting Optima provide the information to someone else. Example: 'Review of claims paid to Dr. Smith'.

6. Step 3, #6 & #7: This is the name and the address of the person who you wish to receive copies of the documents you are requesting.

7. Step 3, #8: This allows you to determine when you want this form to expire. If you do not put a date in, this authorization will expire in two (2) years from the date signed.

8. Step 4, #9: This is **your signature** or the signature of the person who has the authority to sign this type of document for you. This section is for Drug and Alcohol Abuse Medical Records.

9. Step 4, #10: This is the relationship between you and the person who has authority to sign documents for you. **ONLY** fill this line out **IF** someone other than you has signed the form.

10. Step 5, #11: This is **your signature** or the signature of the person who has the authority to sign this type of document for you.

11. Step 5, #12: This is the relationship between you and the person who has the authority to sign documents for you. **ONLY** fill this line out if someone other than you has signed the form.

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

Last Revised: 07/25/17

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

Discrimination is Against the Law

Optima Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Optima Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Optima Health:

- 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)
- 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:

Civil Rights Coordinator
4417 Corporation Lane, Virginia Beach, VA 23462
1-844-801-3779, 757-552-7116 Fax
languagehelp@sentara.com

If you believe that Optima Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Section 1557 Coordinator
4417 Corporation Lane, Virginia Beach, VA 23462
1-844-801-3779, 757-552-7116 Fax
languagehelp@sentara.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator (above) is 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 ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at hhs.gov/ocr/office/file/index.html