OptimaHealth

Authorization for Use or Disclosure of Medical Information

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. _____ **3. _____**
Name **Member ID # or SSN #**

2. ___ ___/ ___ ___/ ___ ___ ___ ___
Date of Birth

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***

HIPAA Release Form

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

Authorization to Release Protected Health Information

Dependents must complete this form to authorize the release of protected health information to the account holder.

Instructions:
1. Dependent authorizing release of info must complete and sign below.
2. Submit completed form to HealthEquity.
3. Retain a copy of this form.
4. HealthEquity does not receive medical or transaction codes from health plans or other health care providers, and therefore, it is unable to limit the information it releases pursuant to this authorization. Signing this form will allow the account holder to receive all of your protected health information. DO NOT SIGN THIS FORM UNLESS YOU AGREE TO RELEASE ALL OF YOUR INFORMATION.

HIPAA Release (to be completed by dependent)

My protected health information is individually identifiable health information, including demographic information collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and relates to: (i) my past, present, or future physical or mental health condition; (ii) the provision of the health care to me; or (iii) the past, present or future payment for the provision of health care to me.

In accordance with the provisions of the Health Insurance Portability and Accountability Act ("HIPAA"), I, the undersigned, grant permission to HealthEquity, Inc. to disclose **all of my** protected health information (as defined in HIPAA) to the following person or persons:

Print Account Owners Name:_____

By authorizing the release of protected health information to the account holder, all claims and claims information provided to HealthEquity will be viewable by the account holder, without regard to claim type or services identified on a claim. **See Instruction 4 above**.

This release will remain in effect until either (i) the closure of the Health Savings Account, Flexible Spending Account, or Health Reimbursement Arrangement, or (ii) my written revocation of this release.

* If at any time you need to alter or revoke this release form please contact HealthEquity at (866) 346-5800.

Authorization of HIPAA Release

I understand that by granting this Release, the person who obtains this information may disclose it to other individuals with or without my consent and in so doing the information may no longer be protected under HIPAA.

Date: _____

Dependent Name: _____

Dependent Signature: _____

Note: If the person signing above is a personal representative of the named individual, attach copy of document granting authority to the personal representative.