DENVER HEALTH MEDICAL PLAN INC.™

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

SECTION A: MEMBER INFORMATION Complete all information requested in this section for the member whose information will be released.		
Name: Last, First, Middle Initial, Title (Sr., Jr., III.)	**Date of Birth:** | |	**Telephone #:** ( ) -
Address:	**Group #:** (as shown on the Member's ID Card)	
City, State, Zip:	**Member ID #:** (as shown on the Member's ID Card)	

SECTION B: AUTHORIZED INDIVIDUALS Please list the individuals and/or organizations that you are authorizing to view or receive your PHI. Include each individual's address and telephone number in case they need to be contacted in an emergency.		
1.	**Name/Organization:**	**Relationship:**
	Address:	**Telephone #:** ( ) -
2.	**Name/Organization:**	**Relationship:**
	Address:	**Telephone #:** ( ) -

SECTION C: DESCRIPTION OF INFORMATION THAT CAN BE RELEASED (CHECK ALL THAT APPLY).
If more space is needed to describe the PHI, please attach an additional page.

◯ Pre-Cert/Referral/ Authorization Information	◯ Enrollment/Benefits	◯ Disease Management
◯ Case Management Information	◯ Payment Information	◯ Pharmacy Information
◯ Demographic Information	◯ Health Management	◯ Claims Information
◯ **ALL OF THE ABOVE**	◯ Other: (Please Specify)	

I understand that my specific authorization is needed to release my information pertaining to the items listed below. By initialing, I authorize release of the following information pertinent to my case:

Pregnancy/Reproductive (initials)	**Psychotherapy/Mental Health** (initials)	**HIV/AIDS** (initials)	**Alcohol/Substance Abuse** (initials)

The information will be used/disclosed for the purpose of:

SECTION D: TIME PERIOD

Unless noted below, the authorized individuals in Section B can obtain your PHI from the coverage date of your plan with Denver Health Medical Plan, Inc.

◯ Only respond to inquiries from (insert date) to (insert date)

SECTION E: SCOPE OF AUTHORIZATION (CHECK ALL THAT APPLY; THIS SECTION MUST BE COMPLETE)

◯ The individual(s) in Section B may **discuss orally** my PHI with Denver Health Medical Plan, Inc.

◯ The individual(s) in Section B may **inspect and/or obtain copies** of my PHI from Denver Health Medical Plan, Inc.

◯ The individual(s) in Section B may **change my Primacy Care Physician (PCP and address)** maintained by Denver Health Medical Plan, Inc.

SECTION F: PERSONAL REPRESENTATIVE INFORMATION

Complete this section if you are a personal representative that is acting on behalf of a member. You must include a copy of one of the following documents as proof of your legal representation and authority:

- Valid Health Care Proxy
- Certificate of Guardianship Documentation
- Power of Attorney
- Valid Designation of Client Representative (DCR) Form

If the member is deceased, please include one of the following:

- Administrator's or Executor's Certificate
- Surviving Spouse's Certificate

Name: Last, First, Middle Initial, Title (Sr., Jr., III.)	**Relationship:**
Address:	**Telephone #:** ( ) -

By signing this form, I understand the following: (1) if the entity authorized to receive my PHI is not a health plan, health care provider or other covered entity as described by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, the released information may no longer be protected by federal and state law governing the use/disclosure of protected health information; (2) I may revoke this authorization at any time by notifying Denver Health Medical Plan, Inc. in writing; (3) if I do revoke this authorization, my revocation will have no effect on any action Denver Health Medical Plan, Inc. took according to this authorization before Denver Health Medical Plan, Inc. received my revocation; (4) it is my choice to sign this form and I do so voluntarily. Signing or not signing this authorization form will not affect any payment, enrollment, eligibility, or benefit coverage decisions made by Denver Health Medical Plan, Inc.

I sign this authorization under penalty of perjury and attest that the information contained in this authorization is true and correct and may be relied upon by Denver Health Medical Plan, Inc.

Signature of Member or Personal Representative:	**Date:** | |
Print Name:	**Relationship to Member:**

IMPORTANT NOTE

◯ **Yes, I would like a copy of this form for my records.**

◯ **No, I do not need a copy of this form for my records.**

SECTION H: RETURN THIS COMPLETED FORM AND SUPPORTING DOCUMENTATION TO:

Mail: Denver Health Medical Plan, Inc. ATTN: Privacy Officer 777 Bannock Street, Mail Code 6000 Denver, CO 80204	**Secure Fax:** (303) 602-2025 **Email:** PrivacyOfficerDHMP@dhha.org

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