500 Patroon Creek Blvd.
Albany, NY 12206-1057
www.cdphp.com

Dear Member:

Enclosed is a copy of the CDPHP® *Authorization to Release Health Information* form with information about your rights to the disclosure of your information. The *Release of Authorization* form has five sections; please review the instructions for each section prior to completing the form. **A separate form for each member is required**. The form is **not** considered valid until **all** sections are completed.

Section 1—Fill in the name, CDPHP member ID #, and DOB of the individual whose information is subject to the release of personal health information. This section may also be used to identify a minor for whom you are a parent or legal guardian. ***Please note:*** *The member ID# is required to assist in your identification only. The authorization will be applied to all of your CDPHP group health plans regardless of the member ID# provided on this form.*

Section 2—Select the appropriate box or boxes indicating the information that is authorized to be shared. There are **three** options:

Option 1: Authorizes CDPHP to share **all of your health information**.

Note: *This includes potentially sensitive information related to HIV/AIDS, mental health, substance and/or alcohol abuse, genetic testing, family planning, including abortion and sexually transmitted diseases.*

Option 2: Authorizes CDPHP to share all of your health information **except** information specified by you.

Option 3: Authorizes CDPHP to allow the individuals or entities specified by you to change your address, phone number, **and/or** primary care physician (PCP).

Section 3—Fill in the name(s) and phone number(s) of the individual(s) or entities to which CDPHP may disclose your information. You may also choose to allow those individuals to make changes to your address, phone number, and/or primary care physician (PCP). All other enrollment information must be updated at the request of the subscriber, if allowed by your plan.

Section 4—Select the time period for which this authorization will be in effect.

You may choose to select a specific period of time for this authorization to begin and end. For example, if you are 18 years or older and entering college, you may want to give a parent or guardian permission to access your account while you're away at school. If you do not select a start date, the authorization will take effect on the same date as your signature on this form. If you do not select an end date, this authorization will expire in 10 years from the date of your signature.

Section 5—Please indicate the purpose for the release of information. The purpose is the reason you are authorizing the release of information (i.e., review appeal, discuss claims, assist in enrollment process, etc.) ***If you do not wish to specify a reason for the release of information, you must select the 'My Request' field.***

Section 6—Please be sure to read and understand your rights related to this authorization. In the event you are authorizing CDPHP to share a minor's health information for which you are the parent or legal guardian *(please ensure the appropriate legal documentation has been submitted to CDPHP)*, please also indicate your relationship to the individual. Sign **and** date the form **and** print your name next to your signature.

Please note that you will not have the option to view personal health information online for anyone on your policy over the age of 18 even if an *Authorization to Release Information* form has been completed.

If you have any questions about the *Authorization to Release Health Information* form, please contact the member services department Monday through Friday at the phone number listed on your CDPHP identification card.

If you need additional copies of the *Authorization to Release Health Information* form, they are available on in the forms section of our website at www.cdphp.com. Please return the completed form to: **CDPHP Member Services Department, 500 Patroon Creek Blvd., Albany, NY 12206.**

Sincerely,
Laura Kordas
Director, Member Services
Capital District Physicians' Health Plan, Inc.

Authorization to Release Health Information

Section 1

Name _____ **ID #**_____ **DOB** ____ /____ /_____
(MM/DD/YYYY)

By completing this form you are authorizing Capital District Physicians' Health Plan, Inc. and its affiliates (hereafter referred to as "CDPHP®") to disclose your information to the individual or entity identified by you below.

Section 2—I authorize the use or disclosure of the health care information as described below.
You must check box 1 or 2. Box 3 is optional.

☐ 1. All information available in my CDPHP records. This includes information relating to:

- Alcohol and/or Substance Abuse* *(see pg. 2 of this form)*
- Mental Health Conditions
- HIV/AIDS** *(see pg. 2 of this form)*
- Genetic Diseases or Tests
- Family Planning, including Abortion
- Sexually Transmitted Diseases

☐ 2. All information included above *except* _____

_____

☐ 3. Allow the individuals or entities listed below to make changes to my address, phone number, and/or primary care physician (PCP).

Section 3—*This information may be disclosed to the following individuals or entities:*

Name: _____

Phone Number: _____

Name: _____

Phone Number: _____

Section 4—*Enter the dates that the authorization will be in effect. A specific start date and end date must be provided.*

If you **do not indicate a start date**, this authorization will be effective as of the date of your signature on this form. **If you do not indicate an end date**, this authorization will expire 10 (ten) years from the date of your signature.

Start date (MM/DD/YYYY) ____ /____ /_____ to end date (MM/DD/YYYY) ____ /____ /_____

In the case of minor dependent, this authorization will terminate upon the first of the following to occur: written revocation by the undersigned, the expiration date of the time period noted above, or when the named minor dependent reaches the age of eighteen (18) years.

Section 5—The reason I am authorizing the release of information is:

☐ My request ***or*** ☐ Other *(please describe)*: _____

Section 6—Sign and Date This Form

The form must be signed and dated in order to be valid.

_____ _____
Signature Print Name

_____ /_____ / _____ _____
Date of Signature (MM/DD/YYYY) Relationship to Member

Please return completed form to:
CDPHP Member Services Department
500 Patroon Creek Blvd.
Albany, NY 12206

Your Rights Related to The Disclosure Of Your Information

- This authorization is voluntary and you may refuse to sign.
- Your refusal to sign will not affect CDPHP payment for services or your eligibility for CDPHP benefits.
- The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy rules of the Health Insurance Portability and Accountability Act of 1996.
- You have the right to revoke this authorization at any time except to the extent that CDPHP and/or other professionals or entities have already acted in reliance on it.

***Prohibition on Redisclosure of Alcohol and Substance Abuse Related Information**

If information is disclosed from alcohol or substance abuse records protected by Federal confidentiality rules (42 CFR Part 2), these rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by these rules.

****Your Rights Related to the Release of Confidential HIV/AIDS Information**

Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV. By checking the first box and signing this form, medical information and/or HIV-related information can be given to the people listed by you on this form, for the reason(s) listed.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. Under State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of medical and/or HIV-related information are not protected under federal law. The law protects you from HIV related discrimination in housing, employment, health care and other services. For more information call the New York State Division of Human Rights Office of AIDS Discrimination Issues at **1-800-523-2437** or (212) 480-2522 or the New York City Commission on Human Rights at **(212) 306-7500**. These agencies are responsible for protecting your rights.

For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.