

Instructions

Please complete this form to allow UPMC Health Plan to fulfill your request to use or disclose your protected health information (PHI) that we have received, collected, or maintained in our files.

As a member of UPMC Health Plan, you have the right to authorize the use or disclosure of your PHI. The federal Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) requires that you provide this authorization in writing.

Please be advised that UPMC Health Plan does **not** receive, collect, or maintain any medical records or hospital charts. You must contact your physicians or hospital for authorizations for these types of records.

Your privacy and rights are important to us. To ensure that your records are properly protected, we need to have written confirmation of the details of your authorization for use or disclosure of your PHI.

Once you return this completed, signed, and dated form to us, we can verify your information, prepare your records accordingly, and use or disclose the PHI as detailed in this form.

Please read this form carefully and fill it out completely.

Please print or type in the requested information. If printing, please use a pen.

Member Name:	Member ID Number:
Member Address:	Date of Birth:
Phone Number:	

I, the above-named member, authorize UPMC Health Plan to use or disclose my PHI as follows:

1. Required information

I am authorizing UPMC Health Plan to use or disclose this type and amount of information (check the appropriate items and/or write in any other specific records, where indicated):

- Medical claims
- Pharmacy claims
- Dental claims
- Previously filed complaints and grievances
- Other: _____

I am also authorizing the use or disclosure of the following records:

- Behavioral health claims
- Reproductive health claims
- Chemical dependency claims
- HIV claims

Dates requested: _____

2. Person or organization to whom disclosure is to be made

I authorize use or disclosure of the above-indicated records to the following:

Name:	
Company/Organization:	
Address:	
Telephone Number:	Fax Number:

3. Expiration of authorization

The expiration date (or event) for the use or disclosure authorized in this form is _____.
(If no expiration date is indicated, UPMC Health Plan will use the end of the current plan year for your health benefits. If this use or disclosure is for research purposes, please write in "none" or "at end of research.")

4. Need to renew authorization

If I do not revoke this authorization, I understand that it will expire on the expiration date indicated above. If I wish to extend the authorization disclosure period, I will complete and return a new form.

5. Right to revocation

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and submit my written revocation to the UPMC Health Plan Member Services Department. I understand that this revocation will not apply to information that has already been released pursuant to the instructions described in this form.

6. Lack of conditions

I understand that I do not need to sign this form to receive health care treatment or payment, enroll in my health plan, or be eligible for health care benefits by UPMC Health Plan.

7. Risk of disclosure to persons not covered under the HIPAA Privacy Rule

I understand that the HIPAA Privacy Rule is meant to ensure the privacy of my health information. I also understand that once my PHI is disclosed according to my instructions on this form, the information may be subject to redisclosure if it is provided to persons who are not subject to the HIPAA Privacy Rule. The disclosed PHI may then no longer be protected by the Privacy Rule. I understand that this is particularly important in the case of any disclosure of my PHI to my employer.

8. Right to retain a copy of the authorization

I understand that I have the right to retain or receive a copy of this form.

Please check here if you are not making a copy of this form for your own records and want to receive a copy from UPMC Health Plan.

(Required) Member Signature: _____ Date: _____

Please note

A. In the event that the member is a minor or otherwise legally incompetent, please provide the name, address, and relationship to the member of the person who is signing this form.

Name: _____ Relationship: _____

Address: _____

B. If this form is being submitted by the member's personal representative, please sign below.

Personal Representative Signature: _____ Date: _____

Please return this completed form by mail to:

UPMC Health Plan
PO Box 2965
Pittsburgh, PA 15230-2965

Or by fax to:

412-454-7829

If you have any questions about this form, please call the Member Services Department at the telephone number on the back of your ID card.

Nondiscrimination Notice

UPMC Health Plan¹ complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or gender expression. UPMC Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or gender expression.

UPMC Health Plan:

- Provides free aids and services to people with disabilities so that they can 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 the Member Services phone number listed on the back of your member ID card.

If you believe that UPMC Health Plan has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or gender expression, you can file a complaint with:

Complaints and Grievances
PO Box 2939
Pittsburgh, PA 15230-2939

Phone: 1-888-876-2756 (TTY: 711)
Fax: 1-412-454-7920
Email: HealthPlanCompliance@upmc.edu

You can 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 <https://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, DC 20201, 1-800-368-1019. TTY/TDD users should call 1-800-537-7697.

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

¹UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC for You Inc., and/or UPMC Benefit Management Services Inc.

Translation Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-489-3494 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-489-3494 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-489-3494 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-489-3494 (телетайп: 711).

Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzsch, kannsch du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-855-489-3494 (TTY: 711).

주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 1-855-489-3494 (TTY: 711) 번으로 전화해 주십시오 .

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-489-3494 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-489-3494 (رقم هاتف الصم والبكم: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-489-3494 (ATS: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-489-3494 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-489-3494 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-489-3494 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-489-3494 (TTY: 711).

សម្គាល់: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ យើងមានផ្តល់សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខ 1-855-489-3494 (TTY: 711)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-489-3494 (TTY: 711).

UPMC HEALTH PLAN

U.S. Steel Tower, 600 Grant Street
Pittsburgh, PA 15219

www.upmchealthplan.com

