



Authorization to Release Dependent Protected Health Information

Section I: Please print clearly

I, _____, on behalf of my minor child _____ hereby authorize the use or disclosure of my minor child's protected health information as described below.

CoreSource Member ID Number _____ Member E-mail _____

Member Address _____

City _____ State _____ ZIP Code _____

Member Phone # _____ Minor Dependent Date of Birth ____/____/____

Section II: I, on behalf of my minor child, authorize: (Please select all that apply)

- OSU Health Plan, CoreSource-Medical Claims, Zelis Healthcare, Mental Illness, Substance Abuse, Other (Must be specific): _____

Section III: I, on behalf of my minor child, authorize the release of protected health information to:

(NOTE: One (1) designated representative allowed per member.)

Name _____ Relationship to the member _____ Phone _____ Address _____ City _____ State _____ ZIP Code _____

Section IV: Purpose of Disclosure: Benefits Questions/Issues, Legal Case, Claims Assistance* (NOTE: * CoreSource should be marked in Section II.)

Other (Must be specific): _____

Section V: Specific information to be disclosed (Optional):

- Date(s) of Service: _____ Related Diagnosis: _____ Other (Include specific date/date range): _____

This form must be accompanied by signature page on second page of this form



THE OHIO STATE UNIVERSITY

HEALTH PLAN

Section VI: This authorization will expire: (Please select one) - 365 days (on the date signed)

Less than 365 days (please give specific date or event) _____

I understand that my express consent may be required for the disclosure of information relating to sexually transmitted diseases, AIDS, HIV, mental illness, psychiatric treatment, and/or drug or alcohol abuse treatment. If I have been tested, treated, or diagnosed with any such injury, disease, or illness, OSU Health Plan is specifically authorized to disclose information relating to such diagnosis, testing, or treatment, as directed in this Authorization.

For claims covered by 42 CFR Part 2 (alcohol and substance abuse): This information has been disclosed to you from claims protected by Federal Confidentiality Rules. The Federal Rules Prohibit you from making 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 42 CFR Part 2.

I understand that I am not obligated to sign this authorization form, that I do so voluntarily, and that payment will not be conditioned on my signing. However, I also understand that my child's enrollment in a health plan or eligibility for benefits may be conditioned on provision of this authorization, if it is for a health plan's eligibility or enrollment determination relating to my minor child.

I understand that I may revoke this authorization at any time, except to the extent that OSU Health Plan may have taken action in reliance thereon, by sending a written revocation to the Ohio State University Health Plan Privacy Officer, and once processed, no further information will be disclosed under this authorization. I also understand that OSU Health Plan cannot limit or control the subsequent use, reproduction or dissemination of the health information I have authorized to be released. **The revocation of this authorization is effective except as indicated in The Ohio State University's Notice of Privacy Practices.**

A copy of this Authorization is a valid as the original. Digital/electronic signatures are not accepted.

Signature of Member Authorized to Act on Behalf of Minor Child

Print Name

Date Signed

If Personal Representative, source of authority to act for Member

For this Authorization form to be valid, it must be filled out accurately and completely.

Return this form to the HIPAA Privacy Officer, OSU Health Plan, Inc., 700 Ackerman Road, Suite 1007, Columbus, Ohio 43202 or fax to (614) 292-8666.

FOR OFFICE USE:

APPROVED BY: _____
OSU Health Plan Privacy Officer

DATE: _____

REASON DENIED: _____

DENIED BY: _____
OSU Health Plan Privacy Officer

DATE: _____