



Authorization to Release Protected Health Information

Section I: Please print clearly

I, \_\_\_\_\_, hereby authorize the use or disclosure of my protected health information as described below.

Section II: OSU Health Plan Member/Dependent Information:

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ CoreSource Member ID Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Section III: I authorize: (Please select all that apply)

- OSU Health Plan, CoreSource-Medical Claims, Zelis HealthCare, Mental Illness, Substance Abuse, Other (please specify)

Section IV: I authorize the release my protected health information to:

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

Name \_\_\_\_\_

Relationship to the Member/Dependent \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

- Section V: Purpose of Disclosure: Benefits Questions/Issues, Legal Case, Claims Assistance\* (NOTE: \*CoreSource should be marked)

Other (Please be specific): \_\_\_\_\_

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

Date(s) of Service: \_\_\_\_\_

Related Diagnosis: \_\_\_\_\_

Other (Specific date(s) & diagnosis/information: \_\_\_\_\_

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



**THE OHIO STATE UNIVERSITY**

HEALTH PLAN

**Section VII: 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 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 me.

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 signatures are not accepted.**

\_\_\_\_\_  
**Signature of Member/Dependent, Person Authorized to Consent or Wellness Representative**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date Signed**

\_\_\_\_\_  
**If Personal Representative, source/document 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) 292-8366.

FOR OFFICE USE:

APPROVED BY: \_\_\_\_\_  
OSU Health Plan Privacy Officer

DATE: \_\_\_\_\_

Reason Denied: \_\_\_\_\_

Denied BY: \_\_\_\_\_  
OSU Health Plan Privacy Officer

DATE: \_\_\_\_\_