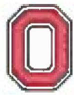


THE OHIO STATE UNIVERSITY
HEALTH PLAN

# Authorization to Release Protected Health Information

**Please print clearly**

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

**OSU Health Plan Member/Dependent Information:**

Date of Birth ___/___/____ NGS Subscriber Number ____________________

Address ________________________________________________________________

City ____________________ State ________________ ZIP Code __________________

Phone ______________________ E-mail ___________________________

**I authorize:** (Please select all that apply)

☐ OSU Health Plan ☐ Dental Claims ☐ NGS-Medical Claims ☐ Vision Claims ☐ Express Scripts-Prescription ☐ Global Care

☐ Mental Illness ☐ Substance Abuse ☐ Other (please specify) ____________________________________

**I authorize the OSU Health Plan to release my protected health information to:**

Name _______________________________________________

Relationship to the Member/Dependent ____________________ Phone ____________________

Address _______________________________________________________

City ______________________ State __________________

ZIP Code ____________________

**Purpose of Disclosure:** ☐ Benefits Questions/Issues ☐ Legal Case ☐ Claims Assistance

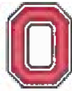
☐ Other (Please be specific): __________________________________________________________

**Specific information to be disclosed:**

☐ Date of Service: ______________________ ☐ Related Diagnosis: ___________________________

☐ Other: ____________________________________________

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



**THE OHIO STATE UNIVERSITY**
HEALTH PLAN

**This authorization will expire:** (Please select one) - ☐ 365 days after it is 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.**

**<u>A copy of this Authorization is a valid as the original.</u>**

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

______________________________________________ ______________
**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 440, Columbus, Ohio 43202 or fax to (614) 292-2667.**

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**FOR OFFICE USE:**

**APPROVED BY:**______________________________ **DATE:**____________________
**OSU Health Plan Privacy Officer**