

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

1. **Member Information** (This is the person whose information is to be disclosed):

Member Name: _____
Date of Birth: _____
Member ID # (Located on your identification card): _____
Phone _____
Address _____

2. **I authorize the following entity(ies) to disclose my health information:**

- ☐ Highmark Inc.
- ☐ Highmark Delaware
- ☐ Highmark West Virginia
- ☐ Highmark Western and Northeastern New York
- ☐ Highmark Wholecare
- ☐ Highmark Health Options

3. **The above entity(ies) may disclose my health information to the following recipient:**

Name (or title) and organization _____
Relationship _____
Address _____
City, State, Zip _____
Phone _____

4. **Information to be Disclosed** (Check all that apply):

☐ **All** protected health information (except psychotherapy notes) including all demographic information, email addresses, phone numbers, prescription information, claims information, and other information contained in a medical record in the possession or control of Highmark.

OR

- ☐ Enrollment Information
- ☐ Claims Information
- ☐ Website Login and Related Information
- ☐ Spending Account Information
- ☐ Premium Billing Information
- ☐ Other (if you would like to limit the disclosure of your authorized information, please describe here): _____

5. Additional Consent:

I understand I must initial to release the following information. If the health information described above includes **SUBSTANCE USE DISORDER, MENTAL HEALTH**, and/or **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and I initial the line below, I specifically authorize release of such health information to the above-named organization or individual.

Include: *(Indicate by Initialing)*

___ Substance Use Disorder Information

___ Mental Health Information

___ HIV/AIDS-Related Information

6. Reason for Disclosure:

☐ Member Request

☐ Other: _____

7. Expiration (You must specify an expiration date or event. If no date is provided, this authorization will expire one year from signature.):

This authorization will expire:

☐ This specific date: _____

☐ When my coverage ends

8. My Rights:

I understand that I do not have to sign this form. I have the right to take back (“revoke”) my authorization. To take back my authorization, I must send a written notification to my health plan at the address listed below. If my health plan has already acted based on my authorization, revoking it will only prevent future disclosures.

If I authorize or refuse to share this information, it will have no effect on my treatment, payment, enrollment in a health plan, or eligibility for benefits. I understand that the information shared under this form might be re-shared by the recipient and will no longer be protected by law.

I may request to receive a copy of this form after I have signed it.

9. Signature:

Print Name: _____

Date: _____

Signature of Member or Personal Representative* _____

***If you are signing this authorization form on the member’s behalf as their personal representative, you must attach copies of your legal document in order for this authorization to be processed.** Where applicable, please include power of attorney, healthcare surrogate, or guardianship papers with this authorization. Please also provide the following information:

Your name: _____

Relationship to member: _____

Please submit your completed authorization form to us on your member app or website by clicking “Send a message” under the Support tab or via mail to:

Highmark Inc.,
Customer Service
P.O. Box 890035
Camp Hill, PA 17089-0035

If you have any questions or need assistance in completing this form, please call the Customer Service telephone number on the back of your identification card.

Disclosures:

Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association:

Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life, Highmark Senior Health Company, Highmark Care Benefits Inc., or Gateway Health Plan, Inc. d/b/a Highmark Wholecare.

Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company, Highmark Senior Health Company, or Gateway Health Plan, Inc. d/b/a Highmark Wholecare.

PA: Your plan may not cover all your health care expenses. Read your plan materials carefully to determine which health care services are covered. For more information, call the number on the back of your member ID card or, if not a member, call 866-459-4418.

Delaware: Highmark BCBSDE Inc. d/b/a Highmark Blue Cross Blue Shield or Highmark BCBSDE Health Options Inc. d/b/a Highmark Health Options.

West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company, Highmark Senior Solutions Company, or Highmark Health Options West Virginia Inc. d/b/a Highmark Health Options and Highmark Blue Cross Blue Shield. Visit <https://www.highmarkbcbswv.com/networkaccessplan> to view the Access Plan required by the Health Benefit Plan Network Access and Adequacy Act. You may also request a copy by contacting us at the number on the back of your ID card.

Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield.

Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.