Four Gateway Center
444 Liberty Avenue Suite 2100
Pittsburgh, PA 15222-1222

{Mailing Label}
{Mailing Label Address 1}
{Mailing Label Address 2}
{Mailing Label City, State Zip}

Four Gateway Center
444 Liberty Avenue Suite 2100
Pittsburgh, PA 15222-1222

[DATE]

[NAME]
[ADDRESS]
[CITYSTATEZIP]

Dear [NAME]:

Please find enclosed an Authorization to Use and Disclose Protected Health Information Form. Submitting this form is optional. You do not need to complete it unless you want to give us permission to share your claims or medical information with someone else. This could include your spouse, a family member or friend.

In order for Highmark Wholecare to process your request, you must complete all sections of the form. If you are completing this form for someone else, there may be additional information that we need.

Included in this packet:

- Instructions
- The Authorization to Use and Disclose Protected Health Information Form – **2 sides**
- A Non-discrimination Notice
- Self-addressed stamped envelope

If you have any questions, please contact Member Services at 1-800-685-5209, 8 AM to 8 PM, Monday – Friday (TTY: 711). Please return the completed form in the enclosed self-addressed stamped envelope.

Sincerely,

Corporate Compliance and Privacy

Version 2.0 NS_1422 (12/21) Update 12/15/21

Instructions to complete the Highmark Wholecare Authorization to Use and Disclose Protected Health Information Form

Section A: Member Information

1. Write the first and last name of the member whose information is being disclosed.
2. Write the member's identification number.
3. Write the member's address.
4. Write the member's date of birth.
5. Write the member's telephone number.

Section B: Information to Use and Disclose

1. Check what information you would like used or shared. Check all that apply.
2. Please note that some records require special permission to release. Check all that apply.
3. Check who is authorized to disclose the information. In most cases this will be **Highmark Wholecare**.
4. Write who you are authorizing to receive the information. At minimum, include name and address.
5. Check the reason the information will be used or disclosed. In most cases the information will be used or disclosed at **the member's request**.

Section C: Revocation of Authorization

1. Please understand that you may revoke this authorization at any time by giving written notice of your revocation to Highmark Wholecare. Revocation of this authorization will not affect any action Highmark Wholecare took in reliance on this authorization before we received your written notice. Your revocation may be sent to: Privacy Officer, Four Gateway Center, 444 Liberty Avenue, Suite 2100, Pittsburgh, PA 15222.
2. Unless otherwise revoked, this authorization will expire at the termination of your coverage with Highmark Wholecare. If you would like it to expire at a different date, please write that date in the lines provided at the end of Section C.

Section D: Signature

1. This Authorization must be signed and dated by the member whose information is to be released.
2. If the member is unable to sign this Authorization, a personal representative with legal authority on file with Highmark Wholecare may sign and date the form.

Section E: Personal Representative – Optional

A Personal Representative is a person entitled to act under applicable law to act on behalf of a Highmark Wholecare member. This section should only be completed if another individual has legal capacity to sign on behalf of the member. You may end this designation at any time in writing.

1. Write the full name of the personal representative the member is choosing to elect.
2. Write the personal representative's telephone number.
3. Write the personal representative's address.
4. Write the personal representative's relationship to member.
5. Write the type of legal document that grants your personal representative authority to make decisions on your behalf. Examples include: Power of Attorney, Custodial Order, Guardianship, Executor of Estate, etc.
6. Attach a copy of the legal document.

Parents and Legal Guardians

If you are the parent or legal guardian of a minor child, you do not need to complete this authorization if our records show you are the head of household or we have other information in our records to show you are the child's parent or legal guardian. If you would like a copy of the minor child's records, please complete an Access Request. Only complete this form if you want us to send the information to someone other than yourself.

HIGHMARK WHOLECARE

Authorization to Use and Disclose Protected Health Information

Section A: Member Information (Please Print)

Member Name:	Member ID:
Address:	
Date of Birth:	Telephone:

Section B: **Information to use and disclose** (check all that apply)

□ Enrollment information □ Claims information □ Payment information □ Managed Care information (Care Coordination, Case Management) □ Explanation of Benefits □ Clinical Records □ All records □ Other (please specify):	Some records require special permission to release. Please release records pertaining to: □ Pregnancy □ Family Planning □ Mental/Behavioral Health □ Developmental Disabilities □ HIV/AIDS Testing or Treatment □ Sexually Transmitted Disease □ Alcohol and/or drug abuse

Who Is Authorized to use or disclose the Information: □ Highmark Wholecare

Who will receive the information: (Please specify) Name: Address:	**Reason the Information Will Be Used or Disclosed**: □ At the member's request □ Coordinating care for dependent or spouse □ Insurance eligibility / benefits □ Claims resolution □ Further medical care □ Other (please specify):

Section C: Revocation of Authorization

I understand that I may revoke this authorization at any time by giving written notice of my revocation to Highmark Wholecare. I understand that revocation of this authorization will not affect any action Highmark Wholecare took in reliance on this authorization before it received my written notice of revocation. I also understand that without my written authorization, Highmark Wholecare may not use or disclose my health information for any reason except those described in Highmark Wholecare Notice of Privacy Practices. Unless otherwise revoked, this authorization will expire:

□ The termination of my coverage □ Other date: _____/_____/_____

PLEASE FILL OUT THE REVERSE SIDE OF THIS FORM

Health benefits or health benefit administration may be provided by or through Highmark Wholecare, coverage by Highmark Wholecare, an independent licensee of the Blue Cross Blue Shield Association ("Highmark Wholecare"). Highmark Wholecare offers HMO plans with a Medicare Contract. Enrollment in these plans depends on contract renewal.

Section D: **Signature**

I understand that authorizing the disclosure of health information is voluntary. I do not need to sign this authorization to receive health care services except if the only purpose for providing me with a service is to obtain health information to disclose to someone else, then I must authorize that disclosure in order to receive the service.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned about my authorization of this disclosure, except if this authorization is sought for the purpose of determining my eligibility for benefits or enrollment, then I must authorize Highmark Wholecare to obtain the necessary information.

I understand that I have the right to revoke this authorization at any time to the address below. I understand that Highmark Wholecare may still disclose information if they have already taken action based on this authorization.

Privacy Officer
Highmark Wholecare
Four Gateway Center
444 Liberty Avenue, Suite 2100
Pittsburgh, PA 15222

I understand that under federal law I do not have to authorize Highmark Wholecare to receive private notes from counseling sessions that are kept by a mental health professional, as a condition of payment, enrollment in a health plan, or eligibility for benefits.

I understand that information disclosed under this authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law.

Signature: _____ Date: _____

If this authorization is signed by someone who is not the member listed at the top of this form, attach any documents (i.e. general power of attorney) that verify the signer's authority to act for the member.

If you are a Personal Representative filling out this form for a Highmark Wholecare member, please write that relationship below and the legal reason that gives you this right (i.e. Power of Attorney, guardian, etc.). If you have not done so, you will be required to fill out Section E of this form, below.

If you are not the member, print your name:	Relationship to member:
Legal form on file:	Telephone number:
Address:	

Health benefits or health benefit administration may be provided by or through Highmark Wholecare, coverage by Highmark Wholecare, an independent licensee of the Blue Cross Blue Shield Association ("Highmark Wholecare"). Highmark Wholecare offers HMO plans with a Medicare Contract. Enrollment in these plans depends on contract renewal.

Section E: Personal Representative (Optional): You have the option to select a Personal Representative to act on your behalf. If you do not want to select a Personal Representative, or already have one, leave this section blank.	
Name:	**Telephone:**
Address: (Please include Street, City, State, and ZIP)	**Relationship to member:**
Type of Documentation: A copy of a Power of Attorney or other court-initiated document must be ATTACHED to this form in order for it to be processed. Attach supporting documentation: Power of Attorney, Custodial Order, Guardianship, Executor of Estate, etc.	

You are entitled to a copy of this authorization after you sign it.