HOW DO I COMPLETE THE HIGHMARK AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION (ADHI) FORM?

Section 1:

1. Identify who will be disclosing the information. In most cases **Highmark** should be entered in this field.
2. Insert the full name of the individual whose information is being disclosed.
3. Insert the individual's birth date.
4. Insert the individual's address.
5. Insert the individual's phone number.
6. Insert the individual's Unique Member ID (UMI).
7. Insert the dates of service to be covered. For example, if Highmark is to disclose records related to a certain hospitalization, the admission and discharge date should be inserted. A time frame may also be entered, generally not to exceed one year. Two separate time frames may be entered to account for two hospitalizations, etc.

Section 2:

This block will rarely be checked, as Highmark should not have copies of psychotherapy notes, except perhaps in our HMS area. **Please note that if this box is checked none of the boxes in Section 3 may be checked.** A separate ADHI must be completed for release of medical information in the event the ADHI form is requesting the release of psychotherapy notes.

Section 3:

This section provides the description of the information to be released. Only check the box(es) corresponding to the information to be disclosed.

If "Other" is checked, a description of the information to be released should be entered on the provided line.

If a "sensitive" diagnosis is to be disclosed, the pertinent boxes in the next section (e.g., HIV/AIDS, drug/alcohol, mental health, etc.) must be checked.

Section 4:

Insert the name of the person or entity who is to receive the information. The purpose of the disclosure should identify what the information will be used for, e.g., appeal of a denied claim, litigation, at the request of the individual.

Section 5:

Highmark or the name of the person or entity listed in Section (1) should be entered in the field indicating who the written revocation should be given to. Revocations for ADHIs should be forwarded to the appropriate Customer Service area identified on the back of the member's identification card. An expiration event or date should be entered. If an expiration date or event is not entered, the Authorization will expire one year from the date of the signature.

The individual should read the remaining paragraphs in Section 5.

The Authorization must be signed and dated by the individual whose information is to be released.
The completed Authorization should be mailed to:

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

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

(1) **I hereby authorize** _____ to

(Name of Releaser -- e.g., Highmark Blue Shield or other entity)

release/disclose the following information of:

Patient/Member Name _____ Date of Birth _____

Address _____

_____

Identification Number _____ Telephone _____

The records to be disclosed cover the following period(s):

From (date) _____ To (date) _____

From (date) _____ To (date) _____

(2) ❑ **Check if this authorization is for psychotherapy notes.**

(If this authorization is for psychotherapy notes, you must ***not*** use it as an authorization for any other type of protected health information.)

(3) **Information to be disclosed** *(Please check only that which applies)*:

Designated Record Set:

❑ Enrollment Information

❑ Claims Information

❑ Payment Information

❑ Managed Care Information (Precertification, 2nd Opinions, Treatment Plans, Care Coordination, Case Management, etc.)

AND/OR

❑ Pharmaceutical information

❑ Consultation reports

❑ X-ray reports

❑ Discharge summary

❑ Progress notes

❑ Explanation of Benefits

❑ History and physical examination

❑ Laboratory tests

❑ Complete health record(s)

❑ Spending Account Information

❑ Website LogIn and Information

❑ Other (please specify) _____

I understand that this will include information relating to (check if applicable):

❑ Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV)

❑ Mental health care

❑ Sexually transmitted disease

❑ Treatment for alcohol and/or drug abuse

❑ Other (please specify) _____

(4) This information is to be disclosed to

_____

(organization, provider entity and/or individual)

by Releaser for the purpose of _____

(state purpose)

(5) I understand that I may revoke this authorization at any time by giving written notice of my revocation to

_____

I understand that revocation of this authorization will not affect any action Releaser took in reliance on this authorization before it received my written notice of revocation. I also understand that without my written authorization, Releaser may not use or disclose my health information for any reason except those described in Releaser's Notice of Privacy Policies and Practices. Unless otherwise revoked, this authorization will expire on the following date, event, or circumstance:

_____

insert date, event, or circumstance—if no date, event or circumstance is included, this Authorization will expire one year after date of member signature

I understand that authorizing the disclosure of this health information is voluntary, and that I can refuse to sign this authorization.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described above are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I understand that Releaser may condition my enrollment or eligibility for benefits on my signing of this authorization (other than for psychotherapy notes), before Releaser enrolls me, to allow Releaser to obtain protected health information from another covered entity to determine my eligibility or enrollment or Releaser's underwriting or risk rating.

I understand that Releaser may condition payment of a claim for specified benefits on my signing of this authorization (other than for psychotherapy notes) to allow other covered entities to disclose protected health information to Releaser that Releaser needs to determine payment of my claim.

Releaser, its subsidiaries, affiliates, employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____

Signature (Patient/Member) Date

_____

Personal Representative Date
(Include a description of such representative's authority to act for the patient/member)

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