Authorization For Disclosure OR Request For Access To Protected Health Information

Read instructions before completing this form. All fields must be completed

RESET

Instructions: To authorize the use and disclosure of your private information (PI) held by Braven Health, please complete the information below, sign in the space provided and return to Braven Health, HIPAA Team, P.O. Box 1458, Newark, New Jersey 07101-1458 or via fax at 973-274-2358.

SECTION A: MEMBER INFORMATION

Name (☐ *Subscriber* ☐ *Dependent):* _____ Date of Birth: _____ / _____ / _____
MM DD YYYY

Subscriber name: _____ Braven Health Member ID #: _____

Address (on file): _____

City: _____ State: _____ ZIP: _____

SECTION B: DESCRIPTION OF DISCLOSURE

1. Identify the dates of service for which you are seeking records: From _____ / _____ / _____ To _____ / _____ / _____
MM DD YYYY MM DD YYYY

2. Check as applicable, or specify other information for disclosure: _____

Medical

- ☐ Claims Payment Records
- ☐ Case Management Records
- ☐ Utilization Management Records (e.g. authorization request records, appeals request records)

Mental Health/Substance Abuse

- ☐ Claims Payment Records

NOTE: for Case Management Records or Utilization Management Records (e.g. authorization request records, appeals request records) you must contact your Mental Health/Substance Abuse provider.

3. Purpose of Disclosure: _____

4. Recipient of Information: (☐ self ☐ 3rd party, If 3rd party, include name, address and phone number): _____

_____

SECTION C- DISCLOSURE OF SENSITIVE INFORMATION

I understand that Braven Health, its affiliates and business partners need a specific authorization to release my protected health information pertaining to the item listed below. By initialing, I authorize the release of the information pertinent to my case.

Initials		***Expiration date***
_____	HIV/AIDS	_____ / _____ / _____ MM DD YYYY

SECTION D - AUTHORIZATION FOR REQUESTED DISCLOSURE

My protected health information is specifically about me, including my name and address and/or medical information. The information was used or created when I received health care or when payment was received for my health care. The information may include my past, present or future physical or mental health or condition.

I understand that if the persons or organizations I authorize to receive and/or use the protected health information described above are not 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 authorize Braven Health, its affiliates and business partners to disclose the above individual's protected health information. I understand that authorizing the disclosure of "protected health information" is not a condition of enrollment in Braven Health of eligibility for benefits or of payment of claims. I also understand that I may revoke this authorization at any time by notifying Braven Health in writing. Nevertheless, this will not affect any action Braven Health or its affiliates and business associates take before the receipt of the notice of revocation.

This authorization will remain in effect until _____/_____/_____ or on occurrence of the following event: _____
MM DD YYYY

_____

_____ Date: _____/_____/_____
Signature of ☐ Member OR ☐ Personal Representative* MM DD YYYY

_____
Print Name

*Check one. If the requestor is other than the member, the requestor must sign the form and attach documentation showing authorization to act on behalf of the member, unless the requestor is already an established Braven Health personal representative with full authority.

INSTRUCTIONS
AUTHORIZATION FOR DISCLOSURE OF PRIVATE HEALTH INFORMATION

General Instructions: All fields are required to be completed unless otherwise specified.
This form must be completed to allow Braven Health to disclose protected health information regarding one of its members to a third party. Please know that generally, Braven Health does not retain protected health information for a period greater than seven (7) years, except for Medicare related records, which are retained for a period of ten (10) years. All fields are required unless otherwise specified. All required legal documents will undergo a validation process. A separate form and documentation is required for every member and for every recipient, if more than one. If you are a documented legal representative, you may make this request and sign the form on the bottom section on behalf of the member.

Section A. Member Information
This section requests information related to the member whose protected health information is being requested for disclosure. *In the name field, check to indicate if you are the subscriber or a dependent.* In the subscriber name field, write the name of the policyholder. The policy holder is the individual who holds the insurance policy with Braven Health.

Since the information in this section is used for verification purposes, the information must match the most current information on file at Braven Health. Please be aware that this form may be denied if the information on the form does not match the information in our systems.

Section B- Description of Information for Disclosure
The requested information in this section will be used by Braven Health to identify the specific protected health information for disclosure.

In this section, the member or requestor will identify the information for which disclosure is being authorized. Braven Health will provide information in accordance with our Records Management policy. In general, Braven Health does not retain protected health information for a period greater than seven (7) years, except for Medicare related records, which are retained for a period of ten (10) years.

Multiple selections from the Medical and/or Mental Health columns can be made, a description of the information requested can be provided, or both.

1. *Dates of service of records.* Identify the dates of service for which you are seeking these records. Provide the date of service range you are authorizing Braven Health to disclose. If no date range is specified, a timeframe of 18 months from the date this form was received will be utilized.

2. *Description of Information to be Disclosed.* Check the appropriate boxes for disclosure. If you are requesting the disclosure of other information not included as an option in the boxes, describe in detail the information you want Braven Health to disclose. You may write 'See attached description' and attach a separate sheet if necessary.

3. *Purpose of Disclosure.* Provide an explanation for the reason you want Braven Health to disclose the described information. Note: You may write 'See attached description' and attach a separate sheet if necessary.

4. *Recipient of Information.* Identify the entity, person or kinds of persons authorized to receive the information requested for disclosure. You must provide the name, address and phone number of the person or entity receiving the information.

Section C- Disclosure of Sensitive Information

1. This section must be completed only if you are requesting Braven Health to disclose information included in the provided category. You must initial on the left side of the category for disclosure and provide an expiration date.

2. This form cannot be used to request the disclosure of Mental Health/Substance Abuse Case Management Records or Utilization Management Records. For disclosures of Case Management Records or Utilization Management Records (e.g. authorization request records, appeals request records), you must contact your Mental Health/Substance Abuse provider.

Section C- *Authorization for Requested Disclosure*

You must provide an expiration date or an occurrence (ie., end of litigation, conclusion of lawsuit, etc) in which the form will no longer be valid. If this information is missing or omitted from the form the request will be deemed invalid and the request will be denied.

Mail this form to:

Braven Health
Attn: HIPAA Unit
PO Box 1458
Newark, NJ 07101-1458

Or Fax to: (973)274-2358