Authorization for Release of Protected Health Information (PHI)

NEW DIRECTIONS®

There are times when you may want your PHI released to other individuals like a spouse, parent, guardian or other family member. Because your records are confidential, we will need your signed consent to release your PHI. Release of PHI includes both written records and verbal information.

Parents/Guardians: We want to be able to speak with you on behalf of your dependent child (over the age of 18 or between ages 14-18 for certain diagnosis) about their PHI. In order to do this, we are required to have their written consent.

If you want to share your PHI with someone else, please complete all sections carefully and return to New Directions Behavioral Health (New Directions).

Section 1 – Person Authorizing Release

First Name

Last Name

Member Identification Number

Date of Birth

Residential Address

City

State ZIP Code +4

Mailing Address (if different from residential address)

City

State ZIP Code +4

I authorize the release of (check one box):

- ☐ All information by all channels (including: telephone, web and written) about eligibility, enrollment, underwriting, premiums, plan benefits, claims, correspondence to or from New Directions and prior authorization or determinations for services provided by any physician or hospital.
- ☐ All documents, records, and other information (excluding psychotherapy notes) from any physician or hospital including information regarding alcohol and substance abuse.
- ☐ Documents, records, and other information to appeal a New Directions decision regarding my claim. May include medical records from my health care providers (excluding psychotherapy notes) and information regarding alcohol and substance abuse.*
- ☐ All documents, records, and other information from the following providers only:

* **Important:** Submission of this form does not constitute an appeal

Pertaining to this time period (check one box):

- ☐ Any or all dates.
- ☐ Range of dates.

  From: _____ (MM DD YYYY) to _____ (MM DD YYYY)
- ☐ Specific date: _____ (MM DD YYYY)

Release my information to (check one box):

- ☐ Individuals listed in Section 2 (next page).
- ☐ All providers and hospitals.
- ☐ The following providers and hospitals only:

Please continue to next page. Your signature is required

Section 2 – Release of Protected Health Information (PHI)

Release my PHI to the following people:

First Name

Last Name

Phone Number Date of Birth

First Name

Last Name

Phone Number Date of Birth

This release of information is for the specific purpose of (check one box):

☐ Assistance with a health plan.

☐ Other (be specific):

Dependent child authorization (under age 18):

☐ I authorize the release of PHI for my dependent(s) listed below:

Release my dependents' PHI to the following people:

First Name

Last Name

Phone Number Date of Birth

First Name

Last Name

Phone Number Date of Birth

Section 3 – Authorization

I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. I understand that New Directions does not condition payment, enrollment, or eligibility for benefits on whether I sign this authorization. This authorization is valid until the termination of my health coverage with New Directions, dependents reach the age of 18, or until such time as written revocation has been received by New Directions.

In addition, I understand that I may revoke this authorization at any time by notifying New Directions in writing and that revocation of this authorization will not affect any action taken in reliance of this authorization before the written revocation was received. **If signing authorization as Power of Attorney, Power of Attorney for Health Care or Guardian/Conservator, a copy of the legal document must accompany this form.**

Your signature required

Applicant Date Signed

Please fax completed document to: (816) 237-2364

Note: Please keep a copy of this form for your files.

The health information disclosed to you may be protected by Federal confidentiality rules (42 CFR Part 2), the HIPAA Privacy Rule, or by State laws. The Federal and State laws prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 or other laws. A general authorization for the release of medical or other health information is NOT sufficient for this purpose. The Federal rules may restrict any use of the information to criminally investigate or prosecute any person seeking alcohol or drug abuse treatment.