OptimaHealth

Authorization for Use or Disclosure of Medical Information (Designated Representative)

Read this information first:

You should complete this form if you wish to authorize Optima Health to use or disclose your medical information to persons who may or may not directly be involved in making decisions regarding your health care. This authorization will remain in effect until the (a) date you specify; (b) date enrollment ends; or (c) the date you withdraw your permission.

**Mail this form to: Optima Health Compliance, PO Box 66189, Virginia Beach, VA 23466 or email to: shpprivacy@sentara.com

(Privacy Statement: Please be aware that email and text communication can be intercepted in transmission or misdirected).

Step 1: Complete the demographic information for the person receiving services:

1. _____ Name
2. ___ ___/ ___ ___/ ___ ___ ___ ___ Date of Birth
3. _____ Member ID # or SSN #
4. _____ Phone number (specify if cell)

Step 2: Tell us what medical information may be used or disclosed:

5. Check the appropriate box to indicate what information may be used/disclosed or changed:
   Claims information ☐ PCP ☐ Address ☐
   Change and/or correct account information ☐
   Other (see instructions) ☐ _____
6. Check the appropriate box to indicate the purpose of the use or disclosure:
   a. At my request ☐
   b. Other (see instructions) ☐ _____

Step 3: Tell us whom you are authorizing to use or receive your medical information:

7. _____ Name of Authorized Person _____ Relationship to Person Receiving Services
8. _____ Address of Authorized Person _____ Cell Phone Number or Email of Authorized Person
9. OPTIONAL: Authorization termination date: ___ ___/___ ___/___ ___ ___ ___

Step 4: Complete and sign this authorization for alcohol and/or drug abuse records:

I acknowledge that information to be used or disclosed as a result of this Authorization may include records that are protected by other federal and/or state laws applicable to substance abuse. I SPECIFICALLY AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION RELATING TO DRUG AND/OR ALCOHOL ABUSE. The recipient of drug and/or alcohol abuse information disclosed as a result of this Authorization will need my further written authorization to re-disclose this information. 42 CFR §2.32 restricts any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

10. _____ ___ ___/___ ___/___ ___ ___ __
Person receiving services or Designated Representative's signature** — Month Day Year

11. _____ ___ ___/___ ___/___ ___ ___ __
Parent/Guardian Signature (if required by State Law) — Month Day Year

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Step 5: Complete your acknowledgement that you understand that:

- You have the right to review the information that is being used or disclosed;
- You do not have to complete this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits;
- The information used or disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by the federal privacy laws;
- You have a right to revoke this authorization at any time by completing and sending to Optima Health a "Revocation of Authorization" Form and
- You have a right to receive a copy of this signed authorization.

12. _____ ___ ___/___ ___/___ ___ ___ _
Person receiving services or Designated Representative's signature** — Month Day Year

13. _____ ___ ___/___ ___/___ ___ ___ __
Designated Representative's relationship — Month Day Year

Attach a copy of the appropriate legal document granting authority if you have signed as the designated representative on behalf of the member

OptimaHealth

INSTRUCTIONS FOR AUTHORIZATION COMPLETION

1. Please **PRINT** information in pen so it is easy to read.

2. Do not skip any steps. Fill all information in as completely as possible.

3. Step1, #1, #2, #3 & #4: This is **your** name, date of birth, your social security number, or your Optima member number.

4. Step 2, #5: This is the information you want Optima to provide. The "other" section allows you to write in a specific description of the medical information or name of the documents not on the checklist. Example: "Claims for Dr. Smith from 2/1/09 to 2/1/10".

5. Step 2, #6: This is a description of the purpose for requesting Optima provide the information to someone else. Example: "Review of claims paid to Dr. Smith".

6. Step 3, #7 & #8: This is the name and the address of the person who you wish to receive copies of the documents you are requesting.

7. Step 3, #9: This allows you to determine when you want this form to expire. If you do not put a date in, this authorization will expire in two (2) years from the date signed.

8. Step 4, #10: This is **your signature** or the signature of the person who has the authority to sign this type of document for you. This section is for Drug and Alcohol Abuse Medical Records.

9. Step 4, #11: This is the relationship between you and the person who has authority to sign documents for you. **ONLY** fill this line out **IF** someone other than you signed the form.

10. Step 5, #12: This is **your signature** or the signature of the person who has the authority to sign this type of document for you.

11. Step 5, #13: This is the relationship between you and the person who has the authority to sign documents for you. **ONLY** fill this line out if someone other than you signed the form.

Call Member Services if you have questions/concerns regarding this authorization form.