QualityHealthPlans
of New York
"Where Quality Healthcare Begins"

Please send completed form to:
2805 Veterans Memorial Highway
Suite 17
Ronkonkoma, NY 11779
Fax: (877) 817-1008

Authorization to Share Personal Information

I am requesting Quality Health Plans (QHP) to release my personal health information, including medical, claim and/or benefit records, to _____.
(Authorized person's name – please print)

These records may have information on specific treatment or services I have received. These records may have information created by others.

This Authorization to Share Personal Information Form allows Quality Health Plans (QHP) to discuss or give out your personal health information to a person you select. The Health Insurance Portability and Accountability Act (HIPAA) requires us to get your permission before we release your information.

SECTION 1: Member Information	
Member Name (please print)	Member ID Number
Permanent Address (City, State, ZIP Code)	
Telephone Number	

SECTION 2: Authorized Person's Information	
Authorized Person's Name	
Permanent Address (City, State, ZIP Code)	
Telephone Number	Relationship to Member

SECTION 3: Expiration and Revocation

I understand that:
1) This authorization expires on my last day as a member of the plan or until QHP receives my written request to end this authorization.
2) I may end this authorization at any time. I must do so in writing. I must send my written request to QHP. I can find plan contact information in my Evidence of Coverage. If QHP has already released any of my personal health information before it receives my written request, my request will not cancel out any requests for information made prior to receiving the written request.
3) This permission is voluntary. I may refuse to sign this form. If I refuse, it will not affect my health benefits.
4) Once health information about me has been given out, it could be redisclosed and it may not be protected by federal privacy laws.

Member Name (please print)	
Member Signature	Date

A witness signature is needed only if the member signs with an "X" due to physical limitations, illiteracy or other reasons. The witness should be someone other than the person/entity named above.

Witness Name (please print)	
Witness Signature	Date

Personal Representative Information (If Applicable)

Name	
Address (City, State, ZIP Code)	
Telephone Number	Relationship to Member: Power of Attorney ____ Guardian ____ Conservator ____ Other ____
Representative Signature	Date

Please Note: This authorization does not allow the person/entity named above to change the plan you are enrolled in, to represent you in a claims appeal, or to make any of your treatment decisions or direct care decisions. If you want someone to make health care and treatment decisions on your behalf, you will need additional legal documentation and will be required to submit a different form.