Authorization to Release Personal Health Information

- This form lets HAP and affiliates share personal and health information.
- It's your choice to allow HAP to share your personal and health information.
- Signing this form does not affect your care, payment, enrollment or eligibility for benefits.

Return to:

HAP Attention: Customer Service
2850 W. Grand Blvd.
Detroit, MI 48202

Or email:

msweb1@hap.org
Please note email isn't safe. It can be viewed when sent.

The form must be filled out, signed and dated.

1. I approve the release of my personal and health info:

Name: _____

Date of birth: _____

Health plan ID number: _____

2. Info to be released. If left blank, HAP assumes this may be disclosed:

- ☐ Enrollment or eligibility (start date, coverage type)
- ☐ Medical management (referrals, services, health type)
- ☐ Claims and billing (status of claims for health services, premium due)
- ☐ Customer service records (network or primary care doctor)
- ☐ Other: _____

_____

Unless you initial, HAP won't give this:

_____ **(initials):**

- Alcohol and drug abuse care
- Psychological or psychiatric care
- Human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS-related complex (ARC)
- Communicable diseases or infections
- Venereal diseases
- Tuberculosis or hepatitis

Alcohol and substance use info disclosed to your approved rep. is protected by federal confidentiality rules (42 CFR part 2) unless:

- you give written okay; or
- as allowed by 42 CFR part 2

_____ **(initials)** psychotherapy notes

3. Release my info to:
   Name: _____ Phone number: _____

   My requested personal and health info can be given by phone, mail, safe email or fax. _____ **(initials)**

4. This release is made by you or your rep. Unless revoked, this expires one year from the date signed unless some other end date or event is written here. We can't accept "indefinitely." You must enter a date or event.

   _____

5. I know I may cancel any time. I must do so in writing. I know info disclosed can't be revoked. My notice must be sent to:

   HAP | Attention: Customer Service, 2850 W. Grand Blvd., Detroit, MI 48202

6. I know if the health plan asked for this, I have the right to get a copy once I sign it.

7. I know the person(s) to whom my info is released by this form may share it to others without my knowledge or okay. The privacy of my personal and health info may no longer be protected by law.

Signature: _____ Date: _____

Printed name: _____

8. If signed by a person other than the member, show the relationship. Give documentation that proves the right of the person to act for the member.

☐ Legal guardian
☐ Parent of minor
☐ Personal rep. of a dead or living person
☐ Power of attorney
☐ Patient advocate rep.

Optional:

1. What language do you speak most of the time? _____
2. Do you need or want a translator to talk with a doctor or health care provider? ☐ Yes ☐ No