Authorization to Release Personal Health Information

- This form lets HAP share your personal and health information (PHI).
- It's your choice to let HAP share your PHI with the people or companies listed below.
- If you sign this form, it won't change your:
    - care
    - payment
    - enrollment
    - eligibility for benefits

Note:
Medicare Advantage or MI Health Link members who need to send a request for an initial coverage determination, appeal or grievance, please also complete the Appointment of Representative Form located at hap.org/appoint.

Return to:

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

Or email:

msweb1@hap.org
Note: Email may not be safe as it may be viewed when sent.

The form must be filled out, signed and dated.

1. I approve the release of my PHI:

Name: _____

Date of birth: _____

HAP ID number: _____

2. PHI to release:

- ☐ Referrals, services, health type
- ☐ Policy details (such as start date and coverage type)
- ☐ Claims and billing
- ☐ Customer service records for the specific inquiry
- ☐ ALL

Note: Medicare and Medicaid members must choose "ALL" if you want PHI sent to third-party vendors of your choice.

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3. Release my PHI to:

Name: _____ Email address:_____ Phone number: _____

Name: _____ Email address:_____ Phone number: _____

Name: _____ Email address:_____ Phone number: _____

My PHI may be given by phone, mail, safe email or fax.

4. This release is made by you or your rep. Unless revoked, this runs out one year from the date signed unless some other end date or event is written here. We can't accept "open ended." You must write an end date or event.

Expiration date: _____ Expiration event: _____

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

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

5. I know if HAP asked for this, I have the right to get a copy once I sign it.

6. Once my rep has access to my PHI, and if they share it without my knowledge, it won't be protected by law.

If I sign this, I approve HAP to give info for the above.

This has info that may be stored in a paper and/or digital format. It may have info on:

- routine medical care
- psychological and social work counseling
- HIV, AIDS or ARC
- communicable diseases or infections, such as STDs, venereal diseases, tuberculosis and hepatitis
- demographic info
- treatment from other health care providers

Alcohol and substance use disorder info disclosed is protected by Federal confidentiality rules (42 CFR Part 2). 42 CFR Part 2 stops unauthorized disclosure of these records. Patient access fee may apply for copies. Fees approved each year by the State of Michigan Medical Records Access Act, P.A. 47 of 2004, MCL 333.26269.

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Signature: _____

Print Name: _____

Date: _____

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

- ☐ Legal guardian
- ☐ Parent of minor
- ☐ Personal rep. of a deceased or living person (if the member is deceased, you must show paperwork that you are executor of the estate)
- ☐ Power of attorney
- ☐ Patient advocate rep.

Health Alliance Plan (HAP) has HMO, HMO-POS, PPO plans with Medicare contracts. HAP Empowered Duals (HMO D-SNP) and HAP Empowered MI Health Link are Medicare health plans with a Medicare contract and a contract with the Michigan Medicaid Program, to provide benefits of both programs to enrollees. Enrollment depends on contract renewals. HAP Empowered Health Plan, Inc., a Michigan Medicaid Health Plan, is a wholly owned subsidiary of Health Alliance Plan of Michigan (HAP). It is a Michigan nonprofit, taxable corporation.

HAP and its subsidiaries do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

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H9712_PHI Release Form 2022_Approved 9/26/22 775 – 9/26/2022