MEMBER CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Use this form if you want to allow someone to see or receive your protected health information.

NOTE: **This form does not allow someone to make changes to your information, request services or file an appeal or grievance.**

If you want someone to help you request a service or file an appeal/grievance, you must complete a Neighborhood Authorized Representative for Appeals form or include a legal document such as a Power of Attorney, Guardianship or Executorship.

INSTRUCTIONS

Section A: **Fill in the members name, address, phone number and Neighborhood ID number**.

Section B: **If you are a member's Personal Representative, please add your name here and attach the proper document** (for example, a signed Power of Attorney).

Section C: **Select the Neighborhood information to share – you can choose all information or just some of it**. If none of the "highly protected" information subjects are checked, they will not be shared.

Section D: **Fill in the person or place that you want to share information with**. Please note: you do not need to complete a form if you want to share information with Neighborhood or a Neighborhood provider.

Section E: **Please choose if you want to share your information for a limited amount of time or for the entire time that you are with Neighborhood**. You can cancel this authorization at any time by writing to Neighborhood at the address below.

Section F: **You or your Personal Representative MUST sign this document**.

Please return this form to:
Neighborhood Health Plan of Rhode Island
Attn: Compliance Department
910 Douglas Pike, Smithfield, RI 02917

Neighborhood Health Plan of Rhode Island complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish: ATENCIÓN: Si habla Español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-459-6019 (TTY 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-459-6019 (TTY 711).

If you need help with this form please call Neighborhood Member Services at 1-800-459-6019 (TTY 711).

Approved #2908, 12/6/19

Neighborhood Health Plan OF RHODE ISLAND™

MEMBER CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

SECTION A: MEMBER INFORMATION

This form can only be used for one member. Please submit a separate form for each member.

NAME		DAYTIME PHONE NUMBER	
ADDRESS			
CITY	STATE	ZIP	MEMBER ID#

SECTION B: PERSONAL REPRESENTATIVE

If you are not the member, please print your name below and then check the box that describes your relationship to the member. **Please attach proof of your relationship to the member (ex. power of attorney, guardianship, etc.).**

Print name of personal representative: _____

☐ **Legal guardian**: Attach guardianship documentation, which must have a court's stamp and signature.

☐ **Power of attorney**: Attach power of attorney (must include authorization of the release of health care information)

☐ **Executor**: Attach letter of appointment of executorship, which must have a court's stamp and signature.

SECTION C: INFORMATION TO BE SHARED (check one)

☐ All information (including personal, health, address, claims, billing and medical records)

☐ Only limited information (such as for specific medical service, dates or billing details)

(describe) _____

Please check below if you would also like to include any of the following which is highly protected:

☐ Substance use records (including alcoholism)

☐ AIDS or HIV treatment records

☐ Mental health services (does not include psychotherapy notes)

SECTION D: PERSON OR ORGANIZATION THAT MAY RECEIVE YOUR INFORMATION

NOTE: Information shared with a person/organization that is not legally required to obey privacy laws is no longer protected.

Print first and last name of the person OR the most detailed name possible for an organization (for example, the name of a law office). Include the reason why you want to share your information such as "assisting in care."

_____ _____

PERSON/ORGANIZATION AUTHORIZED TO RECEIVE YOUR INFORMATION *PURPOSE*

SECTION E: EXPIRATION

This form will expire (check one box only):

☐ On this date (month, day and year): _____

☐ When cancelled or upon my death.

SECTION F: SIGNATURE

I allow the use and sharing of my protected health information as described above at my request. I understand that treatment, payment, enrollment or eligibility for benefits does not depend on whether I sign this form.

_____ _____

MEMBER/PERSONAL REPRESENTATIVE SIGNATURE *DATE*

- MAKE A COPY OF THIS SIGNED FORM FOR YOUR RECORDS –