THE OHIO STATE UNIVERSITY
HEALTH PLAN

Authorization to Release Protected Health Information

PLEASE PRINT CLEARLY & LEGIBLY. All fields & sections on this form are mandatory and must be completed, unless noted as *optional,* for the form to be processed timely.

Section I: OSU Health Plan member/dependent information:

I, _____, hereby authorize the use or disclosure of my protected health information as described below.

Date of Birth _____/_____/_____ Luminare Member ID Number _____

Address_____

City _____ State _____ ZIP Code_____

Phone_____ E-mail_____

Section II: I authorize: (Please select all that apply)

☐ OSU Health Plan ☐ Luminare-Medical Claims ☐ Mental Illness ☐ Substance Abuse

Section III: I authorize the release my protected health information to:
(**NOTE**: One (1) designated representative allowed per member/dependent.)

Name_____

Relationship to the Member/Dependent _____ Phone_____

Address_____

City _____ State _____ Zip Code _____

Section IV: Purpose of Disclosure: ☐ Benefits Questions/Issues ☐ Legal Case* ☐ Claims Assistance*
(**NOTE:** *Luminare should be marked in Section II)

☐ Other (**Must be a specific purpose**):_____

Section V: *Optional*-Must provide specific information to be disclosed:

☐ Date(s) of Service: _____

☐ Related Diagnosis: _____

☐ Other-Specific date(s) & diagnosis/information: _____

This form must be accompanied by signature page on second page of this form

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Section VI: This authorization will expire: (Please select one) - ☐ 365 days (on the date signed) **OR**

☐ Less than 365 days from the date of member/dependent signature
(**Must be a specific date or event**) _____

I understand that my express consent may be required for the disclosure of information relating to sexually transmitted diseases, AIDS, HIV, mental illness, psychiatric treatment, and/or drug or alcohol abuse treatment. If I have been tested, treated, or diagnosed with any such injury, disease, or illness, OSU Health Plan is specifically authorized to disclose information relating to such diagnosis, testing, or treatment, as directed in this Authorization.

For claims covered by 42 CFR Part 2 (alcohol and substance abuse): This information has been disclosed to you from claims protected by Federal Confidentiality Rules. The Federal Rules Prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

I understand that I am not obligated to sign this authorization form, that I do so voluntarily, and that payment will not be conditioned on my signing. However, I also understand that enrollment in a health plan or eligibility for benefits may be conditioned on provision of this authorization if it is for a health plan's eligibility or enrollment determination relating to me.

I understand that I may revoke this authorization at any time, except to the extent that OSU Health Plan may have taken action in reliance thereon, by sending a written revocation to the Ohio State University Health Plan HIPAA Privacy Officer, and once processed, no further information will be disclosed under this authorization. I also understand that OSU Health Plan cannot limit or control the subsequent use, reproduction or dissemination of the health information I have authorized to be released. **The revocation of this authorization is effective except as indicated in The Ohio State University's Notice of Privacy Practices.**

A copy of this Authorization is a valid as the original.

_____ _____
Signature of Member/Dependent, Person Authorized to Consent or Wellness Representative **Date Signed**

_____
Print Name

_____
If Personal Representative, source/document, such as Healthcare Power of Attorney, of authority to act for Member is required.

For this authorization form to be valid, it must be filled out accurately and completely.

Return this form to: The OSU Health Plan, Inc., 700 Ackerman Road, Suite 1007, Columbus, Ohio 43202, fax to (614) 292-8366 or email OSUHealthPlanCS@osumc.edu.

FOR OSU HEALTH PLAN PRIVACY OFFICE USE:

APPROVED BY:_____ **DATE:**_____
OSU Health Plan HIPAA Privacy Officer

Reason Denied: _____

Denied BY:_____ **DATE:**_____
OSU Health Plan HIPAA Privacy Officer