AUTHORIZATION
(Health Plan)

Purpose: This form is used to authorize us to use or disclose protected health information or for another person to disclose protected health information to us for the purpose stated. This form is used for psychotherapy notes, chemical dependency and sensitive diagnosis.

SECTION A: Psychotherapy notes.

☐ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information.

SECTION B: Individual authorizing use and/or disclosure.

Name: ______________________________

Address: ______________________________

Telephone: ______________________ Identification Number: ______________________

SECTION C: The use and/or disclosure being authorized.

Protected Health Information to Be Used and/or Disclosed: Specifically and meaningfully describe the protected health information you are authorizing be used and/or disclosed:

____

____

Entities Authorized to Use or Disclose: Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), including us, who you are authorizing to make use of and/or to disclose the protected health information described above:

______________________ ______________________

______________________ ______________________

Entities Authorized to Receive: Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), including us, to whom you are authorizing the disclosure and subsequent use of the protected health information described above:

______________________ ______________________

______________________ ______________________

Purpose of this Authorization:

☐ At request of individual.

☐ For the following purposes:

____

____

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

Effect of Granting this Authorization: The protected health information described above may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

SECTION D: Expiration and revocation.

Expiration: This authorization will expire (complete one):

☐ On _____/_____/_________

☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

____

____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: ____

Telephone: ____________________ Fax: ____________________

E-mail: ____

Address: ____

INDIVIDUAL'S SIGNATURE.

I, ______________________________, have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Signature: ______________________________ Date: ____________________

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: ______________________________

Relationship to Individual: ______________________________

Please Return This Form To:

Planned Administrators, Inc.
Attn: HIPAA Privacy Coordinator
P.O. Box 6927
Columbia, SC 29260

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.