Authorization for PHI Disclosure

This Authorization for PHI Disclosure Form only needs to be completed if you would like to appoint a personal representative with whom ApexHealth may discuss your private health information and benefit coverage. You are not required to complete this form if you do not wish to appoint a personal representative.

Your privacy is important to us, as are your rights. To ensure that your health information is properly protected, we need to have written confirmation of the details of your request to appoint a personal representative. Please provide the requested information about yourself and the person (or entity) you are designating as your representative. Once you return this completed, signed, and dated form to us, we can verify your request, adjust our records, and speak to your personal representative in a manner consistent with your instructions. Completing and submitting this form does not affect your enrollment, eligibility, or benefits. You have the right to cancel this designation at any time by writing us at the address listed on the following page.

Note: We may discuss your health information with your personal representative. Please read this form carefully and fill it out completely. Please print or type. If printing, please use a pen.

Member Verification – (Please print)
Identification of member: (The following information is needed for verification.)

Member Name: _____ Date of Birth: _____

Phone number where we can reach you if we need to contact you to process your request: _____

Member address: _____

Member ID #: _____

Records to be disclosed – (check all that apply):
Please indicate what information you wish to release by checking one or more of the boxes below.

☐ All Records ☐ Only limited information

If you selected "Only limited information," check all that apply.

☐ Information about your eligibility
☐ Information about your claims
☐ Information about plan enrollment
☐ Information about premium payments
☐ Information about plan benefits
☐ Information Case Management

Indicate by check and initial which highly protected information you allow us to share if any of the boxes below are checked.

_____ ☐ Drug/Alcohol Diagnosis, Treatment & Referral

_____ ☐ HIV/AIDS information

_____ ☐ Mental Health Diagnosis, Treatment & Referral (not including psychotherapy notes)

_____ ☐ Genetic testing information

Purpose of this release of information

Indicate the purpose of the release of your information.

☐ At the request of the individual
☐ Litigation
☐ Other (please describe): _____

Expiration of Authorization

Check only one box below indicating how long ApexHealth can use this authorization to disclose your personal health information (subject to applicable law – for example, your State may limit how long Medicare may give out your personal health information):

☐ Disclose my personal health information indefinitely
☐ Disclose my personal health information for a specified period only

Beginning : _____ (mm/dd/yyyy) Ending: _____ (mm/dd/yyyy)

Entity or person authorized to receive information

Name: _____

Phone number: _____

Address of individual or company
Authorized to receive the information: _____

_____

Check the box describing the person/organization's relationship to you.

☐ Family Member
☐ Friend
☐ Doctor or health care provider
☐ Other, please describe

_____

_____

Please note:

- ApexHealth cannot control what your personal representative does with the information disclosed to him or her, including whether your personal representative discloses the information to third parties, which could result in the information no longer being protected by federal privacy regulations.
- If the information on this form is not complete, ApexHealth will return the form to you, and this request will not be considered until ApexHealth receives the completed information.
- If your Member ID or date of birth is changed, another form will need to be completed at that time.
- You may change or revoke this request by sending a written request to ApexHealth at the address below. Please note that such revocation will not be effective until Apex receives and processes the notification.
- The provision of treatment, payment enrollment or eligibility for benefits does not depend on whether you sign this authorization.

By signing this form, I attest that I have read and understand the above information. My signature authorizes the disclosure of the information described.

Signature of Member, Personal Representative or Parent/Guardian who is authorizing the release:

Signature: _____ Date: _____

We recommend that you keep a copy of your completed form for your records. A copy will be retained by ApexHealth and made available upon your request.

Please return this completed form by Email or Mail:

Scan and Email to: conciergeservices@apexhealth.com
Mail to: ApexHealth ATTN: Legal Dept.
96 Kercheval Avenue Suite 200
Grosse Pointe Farms, MI 48236