SWH
Senior Whole Health

Authorization for Disclosure of Protected Health Information (PHI)

This authorization allows you to select a Designated Representative for your health insurance matters and describes the types of information Senior Whole Health of New York may disclose, discuss and exchange with them. Please complete the enclosed form as follows:

Section 1: Include your name, Medicaid ID, date of birth, address, and the date you would like this authorization to be effective.

Section 2: Select your Designated Representative; a family member, friend, or any trusted person of your choosing.

Section 3: Indicate the types of information you are allowing SWH of NY to disclose to your Designated Representative. Note that we can only disclose the information described in Section 2 if you give specific authorization by signing your initials in this Section. Also, indicate any special instructions in Section 2.

Section 4: Describe the purpose or need to which SWH of NY is authorized to disclose your protected health information to your Designated Representative.

Section 5: This authorization is valid for as long as you are a member of SWH of NY, unless you cancel the authorization in writing.

Section 6: Sign the authorization or have your legal representative sign for you. This section also describes how you may cancel this authorization.

Section 7: Please give the completed white copy of this form to your SWH of NY Outreach Representative or send it to SWH of NY at the mailing address or fax number provided in this section.

You may contact us with questions or concerns by calling Member Services at 1-877-353-0185 (TTY 711) Monday through Friday from 8 a.m. to 8 p.m. (from October 1—March 31, 7 days a week). Interpreter services and alternate format materials are available upon request.

WHAT IS PROTECTED HEALTH INFORMATION? Any information about health status, provision of health care, or payment for health care that can be linked to an individual. This includes any part of a patient's medical record or payment history.

MLTC/H5992_2019_78815_C
Last updated 10/20/2020

Authorization for Designated Representative
for the Disclosure of Protected Health Information (PHI)

1. Your information	
Last Name:	First Name:
Medicaid ID:	Date of Birth:
Street Address:	City, State, Zip:
	Effective Date of Authorization:
2. Assign a Designated Representative (family, friend, trusted neighbor, etc.)	
Last Name:	First Name:
Relationship to Applicant/Member:	Phone:
Street Address:	City, State, Zip:
	Email:
3. Types of information which may be disclosed to your Designated Representative	

SWH of NY is authorized to release the following types of information to your Designated Representative identified in Section 1, above. (Check all that apply.)

- ☐ All Health Plan records that would normally be released to the applicant/member except the information not initialed below.
- ☐ Claim and benefit information
- ☐ Payment and financial information
- ☐ Care of applicant/member information
- ☐ Only specific dates of service: From:_____________To: _____________
- ☐ Other: ____

SWH of NY needs specific authorization to release certain types of protected health information about you. By initialing below, you specifically authorize SWH of NY to release such protected health information to your Designated Representative.

Initial all that apply.	
	Chemical dependency including alcohol or drug treatment
	HIV/AIDS
	Genetic information
	Mental Health Information (excluding psychotherapy notes)
	Sexually transmitted diseases
	Developmental and learning disabilities

Specify any other comments or detailed exceptions for which we may or may not release personal Protected Health Information:____

4. Purpose or need for disclosure. Specify the purpose for which the health information described in Section 2 may be used or disclosed. Check all applicable boxes.

- ☐ Coordinating care
- ☐ Eligibility/benefits
- ☐ Grievance and appeals
- ☐ Claims/billing issues
- ☐ Personal (No specifics; at request of member)
- ☐ Legal investigation
- ☐ Other (please specify)____________________________

5. Effective dates of authorization.

This authorization will remain valid from the date of your signature until your membership in Senior Whole Health of New York ends (disenrollment) or until your application for membership is declined, unless you cancel it in writing.

6. Signature.

I understand that I have the right to receive a copy of this completed authorization form. I may cancel this authorization at any time by sending a written request to Senior Whole Health of New York, 15 MetroTech Center, 11th Floor, Brooklyn, New York 11201. Canceling my authorization will not apply to information that has already been released.

I understand that once the information is released to individuals or organizations that are not health care providers, health plans, or clearinghouses covered by federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

I understand that I am not legally obligated to sign this authorization. SWH of NY may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization when the prohibition on conditioning of authorizations in 45 C.F.R. § 164.508(b)(4) applies.

____ ________________________

Signature of Applicant/Member or Legal Representative **Date**

If signed by a Legal Representative, describe relationship to applicant/member: ______________________

Are you a Durable Power of Attorney or guardian? ☐No ☐Yes If yes, please attach legal documentation.

7. Instructions to Return Form.

Please give this form to your SWH of NY Outreach Representative OR tear off the white copy and **fax this signed form to: 1-855-818-4870** or mail it to Senior Whole Health of New York, 15 MetroTech Center, 11th Floor, Brooklyn, New York 11201.