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# Constituent Authorization Form

A signed authorization to disclose protected health information is required under federal rules implementing the federal Health Insurance Portability and Accountability Act (HIPAA).
This form may also be used to request the use of a member's psychotherapy notes, as defined by HIPAA privacy rules.

## Member Information

| Name *(First, Middle Initial, Last, Title {Sr., Jr., III.})* | Date of Birth *(Month/Day/Year)* |
|---|---|
| Address *(including ZIP Code)* | |
| Member ID Number(s) *(as shown on the member's identification card(s): include any letters that appear in front of each identification number)* | Telephone Number *(including Area Code)* |
| Group Name *(provide name of the group with which the member is currently enrolled)* | Group Number *(as shown on the member's current identification card)* |

**Authorization:** Section I must be completed for all authorizations. Section II must be completed only if member information related to HIV/AIDS, mental health, or substance abuse is to be disclosed, or if psychotherapy notes are used or disclosed.

**Section I:** I authorize this health plan and its affiliates to disclose the above individual's protected health information to:

_____

_____
(You must include the name, address, and phone number of the person or organization receiving the member information.)

Description of the information to be Disclosed: _____

_____

_____

Purpose of Disclosure: _____

_____

**Section II:** I understand that my specific authorization is needed to release my information pertaining to the items listed below. By initialing, I authorize release of the information pertinent to my case:

HIV / AIDS _____ (Initials)
Mental Health _____ (Initials)
Substance Abuse _____ (Initials)
Psychotherapy Notes _____ (Initials) *(See reverse side of form for a description of psychotherapy notes.)*

## Expiration and Revocation

Expiration: This authorization will expire on _____/_____/_____ or on the occurrence of the following event:

_____

_____

**Right to Revoke:** you may revoke this authorization at any time. Contact the Customer Service department of this health plan for further instructions. Your revocation of this authorization will not affect any action taken before receipt of your notice of revocation.

**Personal Representative Information:** Complete this section if a personal representative is authorizing disclosure of the member's information on behalf of the member. See the reverse side of this form for information and directions about personal representatives. A copy of a power of attorney or other count-initiated document will be required, if applicable.

| Name *(First, Middle Initial, Last, Title {Sr., Jr., III.})* | Relationship to the Member |
|---|---|
| Address *(including ZIP Code)* | Telephone Number *(including Area Code)* |

## Signature/Date

I understand the nature of this release. I also understand that if the person or organization I authorize to receive the information described above is not 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. I understand that my authorizing the use and disclosure of my information is not a condition of enrollment in this health plan, eligibility for benefits, or payment of claims.

Signature: _____ Date: _____



The member or member's personal representative must sign and date this form for it to be processed.

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# Directions for Completing the Constituent Authorization Form

The Legislative Constituent Authorization form is for use when a Highmark member desires assistance from their legislator involving communications with Highmark that include protected health information.
This form is used to obtain authorization from the member or the member's personal representative to disclose the member's health information to an individual or organization outside this health plan. This form is used when the information is being disclosed for purposes other than treatment, payment, or health care operations; when psychotherapy notes, HIV, mental health or substance abuse information is being disclosed; or, when written documentation is needed to show that a member has authorized another to receive specific information about them.

**Member Information:** Complete all information requested in this section for the member whose information will be released.

**Important:**

- **Member ID Number(s):** Be sure to include any letters that appear in front of each of the member's identification numbers on their ID card.
- **Group Name and Group Number:** Provide both the group name and group number in which the member is currently enrolled. (Can be obtained from member's ID card.)

**Authorization:** There are two sections here.

**Section I: The first section must always be completed.** It Identifies the individual or organization to receive the information. Describe the information as specifically as possible. If more space is needed to describe the information, attach an additional page. Next, describe why this information is being disclosed.

**Section II:** The second section is to be completed only if the information to be used or disclosed includes psychotherapy notes, or if the disclosure involves HIV, mental health , or substance abuse information.
If this authorization is being used for psychotherapy notes, it can only be used for that specific purpose and no other.

Psychotherapy notes are defined in the Health Insurance Portability and Accountability (HIPAA) Privacy Rules as:

> *Notes made by a mental health Professional that document or analyze the contents of conversations during counseling sessions, which are kept separate from the rest of the member's medical record, and* ***exclude*** *medication, prescription, monitoring, counseling session start and stop times, treatment modalities and frequencies, clinical test results, diagnosis, functional status, treatment plan, symptoms, prognosis, or progress summary.*

**Expiration and Revocation: Expiration information must be completed for an authorization to be valid.** Include a date or a terminating event, such as final claim determination or termination of enrollment, as required by HIPAA privacy rules.

To revoke this authorization, contact the health plan's Customer Service number on your ID card.

**Personal Representative Information:** A personal representative is the member's legal guardian, someone who has power of attorney over the member's health care decisions, or a parent, if the member is a dependent child under the age of 18 and not an emancipated minor. Also, a personal representative can be an executor, administrator, or person legally authorized to act on behalf of a deceased member o the member's estate. **Other than a parent acting on behalf of a dependent child, under the age of 18 who is not an emancipated minor, we require a copy of the power of attorney or other court-initiated document as proof that the individual named should be recognized as the member's personal representative.** For this form to be processed, it is important that a copy of any applicable power of attorney or other court-initiated document is on file with the health plan.

**Signature/Date:** The member or the member's personal representative must sign and date this form for it to be processed.