Authorization for HAP to Release Personal and Health Information

This form, if signed, will authorize **Health Alliance Plan and/or its subsidiary Alliance Health and Life Insurance Co**., (hereinafter referred to collectively as "HAP") to disclose personal and health information held by HAP. Your consent to release information is voluntary and you may refuse to sign this authorization. HAP will not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization.

1. I hereby authorize the disclosure of personal and health information relating to:

   Name: _____
   Date of Birth: _____
   ID No.: _____

2. Information to be disclosed (**If left blank, HAP is entitled to assume that any of the following types of information may be disclosed, if otherwise consistent with this authorization)**:
   - ☐ Enrollment/Eligibility Information (e.g., effective date, type of coverage)
   - ☐ Medical Management Information (e.g., referrals, services received, health status info.)
   - ☐ Claims and Billing Information (e.g., status of claims for health services, premium due)
   - ☐ Customer Service Records (e.g., network or PCP assignment, etc.)
   - ☐ Other (specify): _____
     _____

   Unless initialed, HAP will not disclose information relating to the conditions described below:

   _____ (**initials**): I understand that the disclosed information may include information relating to alcohol and drug abuse treatment, psychological or psychiatric treatment, human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC), communicable diseases or infections, venereal diseases, tuberculosis and hepatitis.

3. **Disclosure is to be made to:**
   Name _____
   Phone Number _____
   Address _____

   The requested information will be provided over the phone or sent by mail. If you want to authorize HAP to fax the disclosure to the above recipient, please provide the fax number here: _____

4. This disclosure is made at the request of the individual or his/her representative. Other purpose(s) for the disclosure, if any, are:_____
   _____

5. Unless otherwise revoked, **this authorization expires one year from the date it is signed**, unless another expiration date or expiration event is written here:_____
   _____

6. I understand that I may revoke this authorization at any time but that I must do so in writing to the plan. The revocation will not be effective to the extent that the plan has already disclosed the information. My notification must be addressed to:

Attn: CLIENT SERVICES DEPARTMENT
Health Alliance Plan/Alliance Health & Life Insurance Co.
2850 West Grand Boulevard
Detroit, Michigan 48202

7. I understand that if the plan requested this authorization, I have the right to receive a copy of this authorization after I sign it.

8. I understand that the persons to whom information is disclosed under this Authorization may possibly re-disclose the information to others without my knowledge or consent and therefore the privacy of my personal and health information may no longer be protected by law.

_____ _____
Signature Date

_____
Printed Name

If signed by a person other than the member, please indicate the relationship and provide documentation that proves the authority of the person to act for the member.

- ☐ Legal Guardian
- ☐ Parent of minor
- ☐ Personal Representative of a deceased or living person
- ☐ Power of Attorney
- ☐ Advance Directive
- ☐ Patient Advocate Designee

To ensure that we are able to best help our members and meet their needs. Please answer the following *optional* questions.

1. What language does the member speak most of the time at home? _____

2. Do you need or want an interpreter to communicate with a doctor or health care practitioner? ☐ Yes ☐ No