Collective Health

Authorization for the Release of Information

This form should be used when authorizing Collective Health to disclose Protected Health Information (PHI) to a specific person or entity. You must complete all the fields on this form. This form is voluntary and can be revoked at any time.

NOTE: This form should not be used for a minor (age 13-17) to provide access to sensitive information. For such access, please complete the "Minor Authorization for Parent Access to Sensitive Information" form.

Section 1: Member whose information is to be released:

Name: _____

Date of birth: _____ Subscriber ID: _____

Last 4 digits of Social Security #: _____ Phone: _____

Section 2: Individual or organization to receive information

Name: _____

Relationship: _____ Purpose of Request: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____

Section 3: Information to be shared

▢ **Full PHI:** Any or all PHI Collective Health maintains, including sensitive services information (e.g., information regarding mental health, substance use and abuse, reproductive care (including abortion), sexually-transmitted disease, genetic testing, etc.)

▢ **Expanded PHI:** Any or all PHI Collective Health maintains except for sensitive services information (*see examples above*).

▢ **Basic Claims Information:** Includes information related to payment of your claims for service you received, including pertinent information located on a claim form (e.g., dates of services, cost of services, general description of services, denial reasons, etc.)

Note: In general, the subscriber of your health plan is permitted under law to see this information for all plan Dependents.

Section 4: Expiration and revocation

This authorization will expire on (must choose one):

▢ One year from the date it is signed

▢ Other (insert date or event): _____

Right to Revoke: You have the right to revoke this authorization at any time by notifying Collective Health in writing. Revoking this authorization will not affect disclosures made before receiving your revocation request.

Minor Authorization: If this Authorization is given by a parent or legal guardian on behalf of a minor, it will expire no later than the minor's eighteenth birthday.

Section 5: Signature

By signing below, you hereby authorize CollectiveHealth Administrators, LLC and its parent company, subsidiaries, affiliates, and subcontractors ("Collective Health") to disclose PHI to the named recipient. Once disclosed, the PHI may no longer be protected by federal and state privacy regulations. Collective Health will not condition payment, enrollment in a health plan, or eligibility for benefits on this authorization. You have the right to receive a copy of this authorization.

Name (print): _____

Signature: _____ Date: _____

If signed by someone other than the Member identified in Section 1 indicate the relationship to the Member:

▢ Parent or Legal Guardian of Minor (under age 18)

▢ Legal representative of Adult Member (age 18+)*

*Note: Legal documents may be required (e.g., power of attorney, guardianship, etc.)

Section 6: Form submission

Submit this form to Collective Health by one of the following methods:

1. Via Secure Messages on the web (at my.collectivehealth.com) or on the mobile Collective Health app.
2. Faxing it to 1-888-974-0998.
3. Mailing it to: Collective Health, ATTN: Member Services, 1557 W. Innovation Way, Suite 300, Lehi, UT 84043.