Authorization for HAP to Release Personal and Health Information

Once signed, this form authorizes Health Alliance Plan or its subsidiary Alliance Health and Life Insurance Company, (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 withhold treatment, payment, enrollment or eligibility for benefits based on whether or not you sign this authorization.

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

   Name: _____

   Date of birth:_____

   Health plan ID number: _____

2. Information to be disclosed (If left blank, HAP assumes that any of the following types of information may be disclosed if otherwise consistent with this authorization):
   - ❑ Enrollment or 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: _____

   _____

   _____**(initials)**: 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 a representative. Other purposes for the disclosure, if any, are: _____

   _____

5. Unless otherwise revoked, this authorization expires one year from the date it's 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 health plan. I understand that information that has already been disclosed by the health plan cannot be revoked. My notification must be addressed to:

   ATTN: Customer Service
   HAP
   2850 West Grand Boulevard
   Detroit, Michigan 48202

7. I understand that, if the health 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 better serve you, please answer the following optional questions.

1. What language do you speak most of the time? _____
2. Do you need or want an interpreter to communicate with a doctor or health care provider?
   ❑ Yes ❑ No

HAP and its subsidiaries do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.
