Indiana Health Coverage Programs

MEMBER AUTHORIZATION

Section A: The Use and/or Disclosure Being Authorized

Purpose of the use or disclosure: Describe the purpose of the requested use or disclosure. If you, as the Indiana Health Coverage Program (IHCP) member are requesting this authorization and choose not to provide a specific purpose, please write the statement "at the request of the individual" in the space provided below:

_____

_____

Health Information to be used or disclosed: Specifically and meaningfully describe the health information records and the dates of the records you are authorizing be used and/or disclosed. *If this authorization is for notes made by a mental health therapist or psychiatrist, no other type of health information may be listed on this authorization*:

_____

_____

_____

Person or Organization Authorized to Use or Disclose: Name or specifically identify the persons or organizations, including the IHCP, who you are authorizing to make use or disclosure of the health information described above: *Please include the address and phone number for persons and/or organizations other than the IHCP.*

Name: _____

Address: _____ Phone Number: _____

Name: _____

Address: _____ Phone Number: _____

Person or Organization to Receive and Use: Name or specifically describe the persons or organizations, including address and phone number, to whom you are authorizing the IHCP to disclose to or let use the health information described above:

Name: _____

Address: _____ Phone Number: _____

Name: _____

Address: _____ Phone Number: _____

I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. State health records privacy will still apply to my health information.

Section B: Psychotherapy Notes

☐ Check if this authorization is for notes made by a mental health therapist or psychiatrist.

If this authorization is for notes made by a mental health therapist or psychiatrist, you must *not* use it as an authorization for any other type of health information records.

(Continued)

Section C: Expiration and Revocation

Expiration: This authorization will expire as follows (complete one):

☐ On _____ / _____ / _____ (DD/MM/YY)

☐ On occurrence of the following event (which must relate to the member or to the purpose of the use or disclosure being authorized.):

_____

_____

Right to Revoke: I understand that I may revoke all or part of this authorization at any time by giving written notice of my revocation to the IHCP Privacy Office information listed below. I understand that revocation of this authorization will *not* affect any action taken in reliance on this authorization before receiving my written notice of revocation.

IHCP Privacy Office
P.O. Box 7260
Indianapolis, IN 46207-7260

Section D: To the member – Complete this section and sign.

Name: _____

Address: _____

City State, ZIP Code: _____ Phone Number: _____

IHCP RID Number: _____ Social Security Number: _____

I, _____ **,** have had the full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to the IHCP. I understand that, by signing this form, I am confirming my authorization that the IHCP may use or disclose to the persons or organizations named in this form the health information described in this form. I also understand that the IHCP will not condition payment, enrollment, or eligibility for benefits in the IHCP on the signing of this authorization.

Signature: _____ Date _____

Section E: To the member's personal representative – Complete this section and sign.

If this request is from a personal representative on behalf of the IHCP member, please provide a copy of the documentation to support the representation and complete the following:

Personal Representative's Name: _____ Date: _____

Relationship to IHCP Member: _____

This form must be notarized if submitted by the member's personal representative.

Subscribed and sworn (affirmed) before me this _____ **day of** _____ **,** _____

Signature: _____

Notary Public in and for the state of _____

In the county of _____

(Affix seal) My commission expires: _____

Please mail this completed form to the following address:
IHCP Privacy Office
P.O. Box 7260
Indianapolis, IN 46207-7260

You are entitled to a copy of this authorization after you sign it.

Please mail this completed form to the following address:
IHCP Privacy Office
P.O. Box 7260
Indianapolis, IN 46207-7260