COX HEALTHPLANS
CoxHealth

Authorization for the Use or Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Cox HealthPlans, LLC may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information (PHI) described herein.

Member's Name: _____ Date of Birth: _____

Address: _____ Social Security # (last 4): _____

City State Zip: _____ Telephone #: _____

I request and authorize ***Cox HealthPlans, 3200 S National Ave Ste B, Springfield MO 65807*** to release healthcare information of the member named above to:

Individual Name: _____

Individual Name: _____

Individual Name: _____

Purpose of request and authorization applies to:

☐ Claims
☐ Benefits
☐ Eligibility
☐ Premium Billing/Payments
☐ Other:_____

Covering the Periods of Coverage:

From (Date):_____ To (Date):_____

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the Home Office of Cox HealthPlans LLC at PO Box 5750, Springfield MO, 65801-5750. Unless revoked, this authorization will expire on the following date or event:_____, or one year from the date of signature, unless otherwise specified.

Drug and Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that my medical or billing records may contain information in reference to drug and/or alcohol abuse, psychiatric care, psychological care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information, I agree to its release. ☐ Yes ☐ No

I understand that if I authorize the release of Drug & Alcohol Abuse treatment records (such as from Center for Addictions)that Federal Law protects those records. The Authorization for Release of Information form does not authorize re-disclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, prohibit information disclosed from records protected by this law from being re-disclosed, even to the patient, without specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. ☐ Yes ☐ No

I understand that once Information is released to the above named person or persons, my information may be subject to re-disclosure. I understand that once information is released, it may be re-disclosed by the recipient and no longer protected by federal privacy regulations. I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless it is for research-related treatments or provided solely to give information to a third party as specified under PURPOSE OF REQUEST. I can inspect or copy the protected health information to be used or disclosed.

Member Signature: _____ Date Signed: _____

Identity of Requester Verified via: (For Office Use Only)

☐ Photo ID, Matching Signature ☐ Other, specify: _____ Verified by: _____

*****This release only allows Cox HealthPlans to speak to the authorized person by telephone or in person. It does not allow the authorized person to make changes or request information to be faxed or emailed on behalf of the member. Any information mailed will be sent to the address on file.**