MEMBER CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Use this form if you want to allow someone to see or receive your protected health information.

INSTRUCTIONS

Section A:	**Fill in your name, address, phone number and Neighborhood ID number.**
Section B:	**Select the Neighborhood information to share – you can choose all information or just some of it.** If none of the "highly protected" information subjects are checked, they will not be shared.
Section C:	**Fill in the person or place that you want to share information with**. Please note: you do not need to complete a form if you want to share information with Neighborhood or a Neighborhood provider.
Section D:	**Please choose if you want to share your information for a limited amount of time or for the entire time that you are with Neighborhood**. You can cancel this authorization at any time by writing to Neighborhood at the address below.
Section E:	**You MUST sign this document**.
Section F:	**If you cannot sign, a Personal Representative can sign if they have the documentation listed (for example, a Power of Attorney)**. A Personal Representative cannot sign this form if it is actually naming them as the Representative.
Please return this form to:	**Neighborhood Health Plan of Rhode Island** **Attn: Compliance Department** **910 Douglas Pike** **Smithfield, RI 02917**

Neighborhood Health Plan of Rhode Island complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish: ATENCIÓN: Si habla Español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-459-6019 (TTY 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-459-6019 (TTY 711).

If you need help with this form please call Neighborhood Member Services at 1-800-459-6019 (TDD/TTY 711).

Neighborhood Health Plan OF RHODE ISLAND™

MEMBER CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

SECTION A: MEMBER INFORMATION

This form can only be used for one member. Please submit a new form for each member.

NAME		DAYTIME PHONE NUMBER	
ADDRESS			
CITY	STATE	ZIP	MEMBER ID#

SECTION B: INFORMATION TO BE SHARED (check one)

☐ All information (including personal, health, address, claims, billing and medical records)

☐ Only limited information (such as for specific medical service, dates or billing details)

(describe) _____

Please check below if you would also like to include any of the following which is highly protected:

☐ Substance abuse records (including alcoholism)

☐ AIDS or HIV treatment records

☐ Mental health services (does not include psychotherapy notes)

SECTION C: PERSON OR ORGANIZATION THAT MAY RECEIVE YOUR INFORMATION

NOTE: Information shared with a person/organization that is not legally required to obey privacy laws is no longer protected.

Print first and last name of the person OR the most detailed name possible for an organization (for example, hospital name and department). Include the reason why you want to share your information such as "assisting in care."

_____ _____

PERSON/ORGANIZATION AUTHORIZED TO RECEIVE YOUR INFORMATION *PURPOSE*

SECTION D: EXPIRATION

This form will expire (check one box only):

☐ On this date (month, day and year): _____

☐ When cancelled or upon my death.

SECTION E: SIGNATURE

I allow the use and sharing of my protected health information as described above at my request. I understand that my treatment, payment, enrollment or eligibility for benefits does not depend on whether I sign this form.

_____ _____

MEMBER SIGNATURE *DATE*

SECTION F: PERSONAL REPRESENTATIVE

If you are not the member, please sign and date below and then check the box that describes your relationship to the member. **If you are not the parent, please attach proof of your relationship to the member (ex. power of attorney, personal representative, etc.).**

Print name of personal representative: _____

Signature of personal representative and date: _____

☐ **Legal guardian**: Attach guardianship documentation, which must have a court's stamp and signature.

☐ **Power of attorney**: Attach power of attorney (must include authorization of the release of health care information)

☐ **Executor**: Attach letter of appointment of executorship, which must have a court's stamp and signature.

- MAKE A COPY OF THIS SIGNED FORM FOR YOUR RECORDS -