

Member Authorization Form



Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This form is to be filled out by a member if there is a request to release the member's health information to another person or company. Please include as much information as you can.

Part A: Member information

Member last name		Member first name		Middle initial	Member date of birth (MMDDYYYY)
Member street address		City		State	ZIP code
Daytime telephone number (with area code)	Cell/mobile telephone number (with area code)	Identification number (see identification card)		Group number (see identification card)	

Part B: Person or company who will receive this information

The following people or companies have the right to receive my information. (They must be 18 years of age or older). Please enter first and last name. By entering first/last name below that person may receive my information.

My spouse (enter first and last name)	My parents (if you are over 18 – enter first and last name[s])
My domestic partner (enter first and last name)	My insurance broker or agent (enter the name of the company and first and last name, if you have it)
My adult children (enter first and last name[s])	Other (enter first and last name [if you have it], name of company, and how it's related to you)

Part C: Information that can be released

I allow the following information to be used or released by **HealthSun Health Plans** on my behalf:

Check only one box.

All my information. This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

Only limited information may be released (check all boxes below that apply to you).

<input type="checkbox"/> Appeal	<input type="checkbox"/> Eligibility and enrollment	<input type="checkbox"/> Referral
<input type="checkbox"/> Benefits and coverage	<input type="checkbox"/> Financial	<input type="checkbox"/> Treatment
<input type="checkbox"/> Billing	<input type="checkbox"/> Medical records	<input type="checkbox"/> Dental
<input type="checkbox"/> Claims and payment	<input type="checkbox"/> Pre-certification and pre-authorization (for treatment approvals)	<input type="checkbox"/> Vision
<input type="checkbox"/> Doctor and hospital		<input type="checkbox"/> Pharmacy
<input type="checkbox"/> Diagnosis (name of illness or condition) and procedure (treatment): _____		

I also approve the release of the following types of sensitive information by **HealthSun Health Plans** (check all boxes that apply):

All sensitive information²

OR

Just sensitive information about topics checked below

<input type="checkbox"/> Abuse (sexual/physical/mental)	<input type="checkbox"/> HIV or AIDS	<input type="checkbox"/> Reproductive health ³ (including abortion, maternity, etc.)
<input type="checkbox"/> Substance use disorder ^{1,2}	<input type="checkbox"/> Mental health	
<input type="checkbox"/> Genetic testing	<input type="checkbox"/> Sexually transmitted illness	

1 Specify time period of records to be disclosed: _____
Description of records that may be disclosed: _____

2 Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by **HealthSun Health Plans** about me. I understand that my substance use disorder records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

3 Reproductive health includes, but is not limited to, both male and female infertility, maternity, pregnancy loss, miscarriage, family planning, birth control, both elective and spontaneous abortion, and any other related care or services.

Part D: Purpose of this approval – Check only one box.

To give out the information as shown on this form.

OR

For this reason(s):

Part E: Date your approval expires – Check only one box.

If this document was not already withdrawn, this approval will end on the earliest of the following dates:

One year from the signature date in Part F.

OR

Earlier than one year and upon the date, event or condition described below:

Part F: Review and approval

I have read the contents of this form. I understand, agree, and allow HealthSun Health Plans to the use and release of my information as I have stated above or as required by applicable law. I also understand that signing this form is of my own free will. I understand that HealthSun Health Plans does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to HealthSun Health Plans I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative/Guardian signature

Date (MMDDYYYY)

X

**Designated Legal Representative/Guardian –
Complete this section only if you have documentation supporting Legal Representation.**

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:

- A copy of a health care, general or Durable Power of Attorney.

OR

- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal representative (print full name)

Legal relationship to member

Legal representative street address

City

State

ZIP code

Signature

Date (MMDDYYYY)

X

Please return the completed form to: **HealthSun Health Plans**

Address: 11430 N.W. 20th Street Suite #300, Miami, FL 33172

Fax: 305-448-5783

Email: info@healthsun.com

Be sure to keep a copy of this form for your records.