ALASKA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION (ACHIA)

Authorization for Release of Protected Health Information

Uses and disclosures of your protected health information not otherwise described in the Notice of Privacy Practices or the laws that apply to the Alaska Comprehensive Health Insurance Association (the "Plan") will be made only with your written permission. If you want the Plan to disclose your protected health information in a manner or to a person not otherwise described in the Notice of Privacy Practices or the laws that apply to the Plan, please provide the information requested below, sign this Request and submit it to Member Services Monday through Friday during the hours of 8:00 a.m. and 5:00 p.m. at 2015 – 16th Street, Great Bend, KS 67530. In the alternative, you may submit this Authorization by depositing it in the United States mail, postage prepaid, and addressed to Member Services, ACHIA, PO Box 1090, Great Bend, KS 67530, or by facsimile to (620) 793-1199.

Individual Information. Please provide the following information:

Member Name: _____ Date of Birth: _____/_____/_____

Member ID No./ Social Security Number: _____ Telephone Number: _____

Address: _____.

Identification of Information to Which This Authorization Applies. I hereby request the Plan to release and disclose the protected health information specified below (please check one or more):

☐ Full record. ☐ Full record for the period ____/____/____ to ____/____/____.

☐ Enrollment information. ☐ Premium / contribution payment information/ banking records held by the Plan.

☐ Claims and billing information relating to the following service or claim (specify date of service and/or medical condition): _____

_____

_____.

☐ Other (please specify): _____

_____.

Identification of Persons / Organization to Which This Authorization Applies. I hereby request that the following persons or organizations be allowed to use and/or receive the protected health information specified above: _____

_____.

Expiration Date of Authorization. This Authorization shall remain in effect until 12 months after termination of benefits under the health plan unless you specify a different time period or revoke the authorization. _____.

Your Rights. By signing and submitting this Authorization, you acknowledge the following statements about your rights: (1) This Authorization is voluntary and you are not required to sign it; (2) You are not required to sign this Authorization to receive health care benefits under the Plan; (3) You may revoke this Authorization at any time prior to its expiration date by notifying the Plan in writing, however, the revocation will have no effect on any actions the Plan may have taken prior to receipt of your revocation; (4) You have the right to inspect and copy the protected health information covered by this Authorization; (5) The information that is to be used or disclosed pursuant to this Authorization may be disclosed by the person(s) or organization(s) authorized by you to receive the information; and (6) You may revoke this Authorization at any time. Your revocation of this Authorization must be in writing and must be signed by you.

_____ _____

Signature Date

_____ _____

Print Name Authorized Representative's Name

Please Note: ***This request must be accompanied by a picture ID (e.g. valid driver's license, passport or other photo ID issued by a government agency).***

If this form is signed and submitted by a person other than the individual identified above, the Plan will require verification of the authority of the person signing on behalf of the individual before this request will be considered complete.