Authorization for Access of Health Information

PURPOSE: This authorization is at my request to permit Avera Health Plans to allow the person(s) identified in Step 3, to have access to my health information with Avera Health Plans.

Which communication tool you are authorizing? Check all that apply.
☐ Over-the-phone inquiries ☐ Written requests ☐ View claims online*

* NOTE: For online access, all members listed on this form must register online, including the member authorizing the release of information, before this transaction will process.

STEP 1 — MEMBER RELEASING INFORMATION: The information listed in this section is to identify the member whose protected health information is to be released. Note: This information can be found on the member ID card.

Name: ______________________________________ Group Number: _________________________

Member ID Number: ____________________________ Date of Birth: ___________________________

STEP 2 — AUTHORIZATION: As a member of Avera Health Plans, I hereby release the following information and authorize the person(s) named below to access my health information in writing, over-the-phone or online:

- Identifying information (example: your name, address, age, gender),
- Health care coverage information,
- Medical records on file with Avera Health Plans and
- Past, present and future claims information.

STEP 3 — MEMBER RELEASE: The following person(s) are allowed access to my health information (please print).

Name: ____ Relationship to Member: ☐ Parent/Guardian or ☐ Other, specify:_________________________

Name: ____ Relationship to Member: ☐ Parent/Guardian or ☐ Other, specify:_________________________

STEP 4 — AUTHORIZATION EXPIRATION: Authorization may be revoked at any time upon written notification. This authorization will expire upon (check one):
☐ When my health coverage ends or
☐ Date, specify: _______________________
☐ Notification in writing

REDISCLOSURE: The information used and disclosed pursuant to this authorization may be subject to redisclosure because the information may no longer be protected by federal privacy regulations. Where information has been disclosed from records protected by federal law pertaining to alcohol/drug abuse records or by applicable state law, federal requirements (42 C.F.R. Part 2) and state requirements prohibit further disclosure without the specific written consent of the person to whom the information pertains, or as otherwise permitted by such law and/or regulation. A general authorization for release of medical or other information is NOT sufficient for these purposes. Unauthorized disclosure of alcohol/drug abuse information and mental health information is unlawful and civil and/or criminal penalties may apply. Federal regulations restrict any use of alcohol/drug abuse information to criminally investigate or prosecute any alcohol or drug abuse patient.

STEP 5 — AUTHORIZATION APPROVAL: My signature below authorizes the release of all such health information as specified above. I hereby acknowledge I have received a copy of this document.

____ ____________________
Member's Signature Date Signed

*If a legal representative signs the authorization form below on behalf of the member, please complete the following information and provide written documentation to support your status.

____ ____________________ ____________________
Legal Representative's Name* (Please Print) Date Signed Relationship to Member

STEP 6 — SUBMIT TO AVERA HEALTH PLANS: **Send completed and signed form to:**
Retain a copy for your records.

Avera Health Plans, Enrollment
5300 S. Broadband Ln.
Sioux Falls, SD 57108-2221
Or fax: **(605) 322-4689**