# Want to Share Your Health Information with Someone?

eternalHealth has got you covered. We're here to support our members and we know that making healthcare decisions alone can be a daunting task. Sharing your health information with someone can allow them to help you with your healthcare needs and be a part of your care journey.

## What is my Protected Health Information and why is it important?

Your *protected health information* (PHI) encompasses detailed items such as your health insurance plan, your plan benefits, your billing and payment information, both your mental and physical health conditions, exam results from test services, any notes your doctor may have for you, and other private details regarding your health. As a health plan, we store this information, but you have the ability to choose how this information is shared.

As suggested by the name, your protected health information is, in fact, protected by law. When you share any information with your provider or plan, it is protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal and state privacy laws. For more information on your privacy rights under HIPAA, the Department of Health and Human Service (HHS) has a frequently asked questions page that you can visit at http://www.hhs.gov/hipaa/for-individuals/faq/index.html.

At eternalHealth, we keep your health information private and protected. Keeping it safe is something we take very seriously. However, we know that sometimes you may need or want some help with your healthcare journey. We just want to remind our members that:

The authority and power are in your hands. You pick who sees your information, when they see your information, and for how long they have access to your private health information.

## Who would I want to share my PHI information with?

If you have someone that you want helping you, whether it be a spouse, partner, family member, friend, or someone else you trust, you may want to share your PHI with them. There might be times when you:

- Suddenly fall ill and need someone to call and talk to a doctor or nurse on your behalf;
- May want someone to check on an existing claim or have them file a new claim on your behalf; or
- May want a child or a caregiver to help handle your bills and discuss your plan options and benefits.

For any of these situations, or in other instances where you might want help with your care, eternalHealth will need to get your permission for another person to have access to your PHI. This allows us to directly communicate with them about the best thing for *you*.

## Who should I share my PHI with?

You're free to share your healthcare information with anyone. Usually, people will share their information with a trusted person or organization that can work alongside them or represent them on their behalf. Typically, this is done so that a member can get help with something in their care process. However, be sure to check federal and state laws to protect yourself and ensure that the people you want to share your information with cannot freely share it.

## When do people stop gaining access to my PHI?

Unless you tell us otherwise, the consent that you provide us will cease sixty (60) days after date you signed the Authorization for Release of Protected Health Information (PHI). This means that they will have access to your information for sixty (60) days.

## Is the PHI form mandatory to fill out?

No, you only need to fill out this form if you'd like to share your PHI with someone. If you'd like to keep your information private to yourself, you're free to skip this form. Either way, your coverage won't be affected!

# Authorization for Release of Protected Health Information (PHI)

# Tell us how to share your PHI.

## Member Details:

Last Name: _____ First Name: _____ M.I.: ____

Date of Birth: ___/___/_____ Member ID: _____

Address: _____

City: _____ State: _____ Zip Code: _____

## What to Share (Select One Only)

☐ All PHI. This includes, but is not limited to, information about your health conditions, treatments, prescription drugs, and billing details.

☐ Limited information. Tell us what you want to share. For example, maybe its information only about a specific health condition or from a certain period of time. Or specific information, like medical, pharmacy, or billing details. Specify in the line below:

_____

Time Period (If applicable): From: ____/____/____To: ____/____/____

No matter which option you chose to share above, we can limit certain details if you specify below. Please check off any of the following that you would NOT like us to share.

☐ AIDS or HIV tests and treatment records
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☐ Drug and alcohol abuse treatment records

☐ Genetic information, like results from gene testing

☐ Mental health treatment records

☐ Psychotherapy records

Purpose of Release:

☐ Personal Use

☐ Continuing Care

☐ Transfer of Care

☐ Insurance Payment/Claim

☐ Litigation/Legal

☐ Social Security Appeal

☐ Social Security Disability Determination

☐ Other: _____

End Date: This form will stay in effect for sixty (60) days. If you'd like to specify a different end date, please specify one: ____/____/____

## Who to Share With:

Last Name: _____ First Name: _____ M.I.: ____

Organization Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Email: _____

Relationship to Member:

Spouse: ___ Parent: ___ Agent/Broker: ___ Sibling: ___

Child: ___ Friend: ___ Other (Specify): _____

- I understand that I have the right to revoke this authorization at any time. To revoke this authorization, I must do so in writing and present my written revocation to eternalHealth. The revocation will not apply to information that has already been released in response to this authorization.
- I understand that I am not required to sign this Authorization to receive health care treatment.
- eternalHealth's records may include records that it received from other organizations. If these records have been used by eternalHealth, and filed in the record eternalHealth maintains about you, these records may be released with your eternalHealth records.
- eternalHealth cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release eternalHealth from any and all liability resulting from a redisclosure by the recipient.

Your signature indicates that you have read and understand this form, and you authorize release of your information as described above.

Member/Personal Representative's Signature: _____

Member/Personal Representative's Printed Name: _____

Date: _____

IMPORTANT: Personal representatives, please attach proof to this authorization that you can act on behalf of the member (e.g., healthcare power of attorney, health care proxy form, healthcare surrogate form, or guardianship papers.)

Please send your completed form to:

eternalHealth
PO Box 1375
Westborough, MA
01581