Concordia Plan Services
PO Box 229007
St. Louis, MO 63122-9007

CONCORDIA PLANS

Toll Free: 888-927-7526
St. Louis: 314-965-7580
Website: ConcordiaPlans.org

HIPAA Authorization Form for Use or Disclosure of Protected Health Information

PLEASE PRINT OR TYPE ALL INFORMATION IN BLUE OR BLACK INK

Clear

A Instructions

By completing this form, you are authorizing Concordia Plan Services and its successors and assigns (collectively, "CPS"), acting on behalf of the Concordia Health Plan (the "Health Plan"), to use and/or disclose your health information – referred to as Protected Health Information ("PHI") that is created and/or received by CPS pursuant to this HIPAA Authorization ("Authorization").

- Complete one Authorization form per Member or Dependent.
- **Return completed Authorization to:**

  HIPAA Privacy Officer
  Concordia Plan Services
  1333 S. Kirkwood Road
  P.O. Box 229007
  St. Louis, MO 63122-9007

- **Note:** If you wish to return this completed form using a faster delivery method, we recommend that you call Concordia Plan Services at 1-888-927-7526 to arrange secure transmission.
  DO NOT RETURN THIS COMPLETED FORM VIA FAX OR UNENCRYPTED EMAIL.

B Member or Dependent Information

Name

Address

City | State | Zip Code | Phone Number

E-mail Address

C Acknowledgement of Privacy Rights

I understand that:

- I have the right to revoke this Authorization, in writing, at any time by sending written notification to**:** Privacy Officer, Concordia Plan Services, 1333 S. Kirkwood Road, P.O. Box 229007, St. Louis, MO 63122**.**
- a revocation is not effective to the extent that CPS has taken action in reliance on this Authorization.
- information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- my Health Plan may not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.
- I have the right to inspect or copy the PHI to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- I have the right to refuse to sign this Authorization.

(Continued on next page)

D Authorization

Protected Health Information for Use and Disclosure. I hereby authorize Concordia Plan Services and its successors and assigns (collectively, "CPS"), acting on behalf of the Concordia Health Plan (the "Health Plan"), to use and/or disclose my health information - referred to as Protected Health Information ("PHI") that is created and/or received by CPS pursuant to this HIPAA Authorization ("Authorization").

Item 1. Authorization and Description of PHI to be Used or Disclosed. I hereby authorize CPS to use and/or disclose the following PHI to the person(s) or entity(ies) listed in Item 2 of this section for the purposes described in Item 3 of this section:

Complete EITHER A or B

☐ A The complete medical record for services rendered on or after the following date:_____
(MM/DD/YYYY)

☐ B Only the following health information:

Specifically describe below the information you authorize the Health Plan to be used or disclosed (e.g. Health Plan contributions); including, but not limited to, date of service, type of service provided, level of detail to be released, origin of information, etc:

_____

_____

_____

_____

_____

Note: Unless expressly limited in Item 1 above, this Authorization grants the Health Plan the right to use or disclose all of your health information for the purposes described, including health information about **any and all** types of diagnosis and/or treatment

Item 2. Party To Whom Information May Be Disclosed. I authorize the release of the PHI described in Item 1 above to the following person(s) or organization(s):

Please **print** *the name of the individual(s), entity(ies), or organization(s) to whom you authorize the Health Plan to disclose PHI.*

_____

_____

_____

Item 3. Purpose of Authorization To Use or Disclose.
Please state the purpose of the disclosure of PHI.

_____

_____

_____

_____

Note: Unless you provide another purpose, the purpose of this Authorization will be for Health Plan administration purposes. This Authorization cannot serve as authorization to obtain health information from your health care provider or from the Health Plan's third party administrators.

Item 4. Duration of Authorization. This Authorization shall be in force and effect until described herein:

Please provide an expiration date OR event. The expiration date or event must either be a specific date (e.g. December 31, 2019), a specific time period (e.g. one year from the date of signature), or an event directly relevant to the individual or the purpose of the use or disclosure (e.g. for the duration of the individual's enrollment with the Concordia Health Plan).

_____

_____

E Signature

If I am signing this Authorization on behalf of a minor, I represent that I have the legal right to provide this Authorization on behalf of said minor.

X_____

Signature of Individual or Parent or Legal Guardian of Minor | Date of Birth of Individual | Today's Date

_____ XXX-XX-_____

Printed Name of Individual or Parent or Legal Guardian of Minor | Social Security Number(**only last 4 digits** of Individual)

Note: Please complete Authorization form in its entirety. Failure to complete the Authorization form in its entirety may cause a processing delay.