**In order for OHA to advocate for you, this form must be complete and accurate. Please review and follow the instructions below, and contact the office at (866) 466-4446 with any questions about this release.**

**SECTION I: CONSUMER INFORMATION**

1. Complete the name, address, phone number(s), e-mail address, gender, and date of birth for the **"Subscriber",** which is the person who obtained the primary insurance policy (e.g., spouse on the spouse's plan).
2. Complete the name, address, phone numbers(s), e-mail address, gender and date of birth for the **"Member or Patient"**, which is the person who is having the issue that you contacted us about.

**PLEASE NOTE:** If this case is related to a child **age 14 or older, with mental health or substance use issues, the child is required to sign** a separate release authorizing release of mental health or substance use records.

**SECTION I-A: DEMOGRAPHIC INFORMATION – This should be completed for the Member, not the Subscriber**

OHA receives federal grants, therefore we are required to collect information on ethnicity, race, marital status, employment, income and veteran status of the **"Member or Patient"** we are serving. We use this information to report on the demographic information of our consumers only. This information is not readily shared.

**Section II: INSURANCE INFORMATION** – Failure to provide information regarding all insurance may delay resolution of your issue.

1. Insurance cards: provide a copy of your card(s) (front and back)
2. Complete this section with the information about your health insurance or Medicaid to fill in the name and address of the insurance company, subscriber ID and group number, employer's name, employee's name and the relationship to the **"Member or Patient"** (e.g., self, mother/father, spouse, etc.) If you have more than one type of insurance, please complete that information for each, and use a separate sheet of paper if necessary. We collect your employer name to help us determine what kind of healthcare coverage you have.

**SECTION III: PRIVATE HEALTH INFORMATION FOR RELEASE**

1. YOU MUST describe what health information you authorize for release and receipt. It is important to capture as much information as possible that is **related** to the case. Please include all dates of service, services received, diagnosis, etc. You should also check next to any specific record types you authorize us to obtain. Please note the special instructions for certain categories of records in this section.
2. Include any additional parties who you authorize to release or receive your health diagnosis and/or insurance information.
3. If you wish us to share information or discuss your case with a spouse, parent or significant other, this must be included on a line under "The Office of the Healthcare Advocate."
4. List the hospitals, doctors and/or providers who have the necessary medical information and whom we may contact. Include the address and phone numbers for each facility/provider.

If necessary, please list additional providers on a separate page, and **initial and date** all hospitals/providers listed on this page.

***Please note that the State of Connecticut regulates fully insured plans. These plans include individual insurance plans and certain group plans, including small group plans.***

**SECTION IV: PURPOSE OF RELEASE**

1. **Purpose**: You must check one option, and if "For the purpose below" is selected, be sure to specify the reason in the section provided; **Authorization**: This is selected automatically, and grants OHA the authority to submit any required appeals on your behalf; **Expiration**: You must select one option and complete area requiring additional information. Many individuals choose the last option and write/type in "at the completion of the case".

**SECTION V: SIGNATURE**

1. Please sign and date the form and include a power of attorney or other applicable document if you are acting on behalf of someone who is not your child or who is incapacitated. **It is important that the minor sign to release certain records.**

**MEDICARE – If you have Medicare, you MUST complete Section I ONLY of page 5 of this release, the Medicare Appointment of Representative form**

If you've completed the form online, please print it and either scan and return it by (1) email to the appropriate staff, (2) fax it to the staff's attention at (860) 331-2499 or (3) mail it to the address shown on the top of page 2.

Office of the Healthcare Advocate
STATE OF CONNECTICUT

**Please complete this form and return via mail**:
Office of the Healthcare Advocate
P.O. Box 1543
Hartford, CT 06144-1543

**Or Fax**: (860) 331-2499 **Or E-mail**: healthcare.advocate@ct.gov

# Authorization for Use and Disclosure of Private/Protected Health Information

NOTE: Your enrollment in a health plan, eligibility for benefits, processing, and payment of claims, or treatment is not a condition of this authorization

**SECTION I: Identification of Person Authorizing Release** (*the following is needed for verification*). *Please complete all applicable items.*

Name of **Subscriber:** John Smith Date of Birth: 04/ 22/ 1988

Address: 123 Main Street

City: Hartford State: CT Zip Code: 06106

What is your current gender identity? Man ◆ Woman ☐ Transgender Man ☐ Transgender Woman ☐ Different Identity ____

Telephone Number(s) (H): 860-555-5555 (W) 860-555-6666

(C): 860-555-7777 (Fax) ____

Email Address*: john.smith@mail.com

**I am the Person Authorized to Release Medical Information for:** ☐ **SELF** (*Skip to I.A*) ■ **CHILD/FAMILY MEMBER** ☐ **OTHER**

Name of **Member/Patient:** Mark Smith Date of Birth: 7 / 15/ 2001

Address: 123 Main Street

City: Hartford State: CT Zip Code: 06106

What is your current gender identity? Man ◆ Woman ☐ Transgender Man ☐ Transgender Woman ☐ Different Identity ____

Telephone Number(s) (H): 860-555-5555 (W) ____

(C) ____ (Fax): ____

Email Address*: mark.smith@mail.com

I would like primary communication via e-mail: ✔ YES ____ NO I would like to receive E-alerts from OHA: ✔ Yes ____ NO

**Section I.A – Requested Demographic Information Specific for the Individual receiving OHA Assistance****

**Member/Patient ETHNICITY.** ____ Hispanic, Latino/a or Spanish ____ Mexican, Mexican American, Chicano/a ____ Puerto Rican ____ Cuban ____ Another Hispanic, Latino or Spanish origin

**Member/Patient RACE:** ✔ White ____ Black or African American ____ Hispanic/Latino ____ Asian American ____ Native Hawaiian ____ Indian/Native American ____ Chinese ____ Guamanion or Chamorro ____ Filipino ____ Japanese ____ Korean ____ Vietnamese ____ Other Pacific Islander ____ Samoan ____ Other

**How well do you speak English?** ✔ Very well ____ Well ____ Not Well ____ Not at all

**If you speak a language other than English at home, what is the language?** ____ Spanish Other Language (identify) ____

**Member/Patient is:** ■ Single ☐ Married ☐ Separated ☐ Divorced ☐ Civil Union ☐ Domestic Partner ☐ Widowed ☐ Child

**Member/Patient is:** ☐ Full-Time employed (☐ one job / ☐ two jobs / ☐ self) ☐ Part-time Employed ■ Student/Minor ☐ Retired ☐ Unemployed (☐ looking for work / ☐ not looking for work) ☐ Disabled / Not working ☐ Unknown

**Member/Patient Income Source:** ☐ Wages ☐ Pension/Retirement ☐ SSI ☐ SSDI ☐ Child Support ☐ Unemployment Benefits ☐ Self-Employed ☐ Other/Unknown ■ None

**Member/Patient heard about OHA:** ■ Insurance Denial ☐Provider/Hospital ☐ Media/Advertisement ☐ State Agency/Legislator ☐ Attorney/Broker ☐ Outreach Event ☐ Referral/Info Line (211) ☐ Federal Agency/Legislator ☐ Social Media/Website ☐ Other: ____

*OHA uses email to communicate with clients. Please be advised that our email communications are made through a secured server, which requires you to complete a one-time set-up to access the secured email(s).

**Please complete the federally requested demograpic information section; this information is used solely for aggregate reporting purposes and will not be shared with any person or entity.

**II. Insurance Information** *(Please provide front and back copy of your card(s). Please use separate sheet for additional insurance carriers)*

**Primary Insurance Company Name:** Acme Insurance Corp
**Primary Insurance Company phone:** 800-555-1234 Enrolled through Access Health CT? □ Yes ■ No
**Patient Member ID card number:** AIC 4567382343
**Group or Account Number on ID card:** 12345678 tfan type (HMOΣ PPO, th{Σ etc.) HMO
**Subscriber's Employer Name:** Acme Industrial
**Subscriber's Employee Name (if different from Member's):** John Smith
**Subscriber's Relationship to Member:** Father

**Secondary Insurance Company Name:** Medicare
**Secondary Insurance Company phone:** 888-333-2273 Enrolled through Access Health CT? □ Yes ■ No
**Patient Member ID card number:** 123456789
**Group or Account Number on ID card:** tfan type (HMOΣ PPO, th{Σ etc.) HMO
**Subscriber's Employer Name:** NA
**Subscriber's Employee Name (if different from Member's):** Mark Smith
**Subscriber's Relationship to Member:** self

**III. Description of Private Health Information to be released:** You **must** describe briefly **in the box** below what information you are authorizing to be released. Describe in detail the kind of information (e.g., claims information, premium information, medical records including test results, etc.) you want released, and if applicable, the date(s) of service/information (e.g., claims for the last 6 months, premium payment record for January, etc.) **Use a separate sheet if necessary.**

Medical records, lab results and all other records relating to the surgery performed on March 1, 2016

In addition, if you agree that the following types of records may be released, please indicate by checking the appropriate boxes:

☑ Progress Notes ☐ Mental Health* ☐ Genetic Testing ☐ HIV/AIDS * ☐ Maternity
☐ Sexual/Physical/Mental Abuse* ☐ Sexually Transmitted/Other Communicable Disease* ☐ Alcohol/Substance Abuse*

***If you want to authorize the use or disclosure of other protected health information as well, an additional form must be submitted. Please see the last page of this authorization, which describes in more detail further disclosure of HIV/AIDS records and Alcohol & Substance Abuse records.**

**The Release and Receipt of Health Information:**

The Office of the Healthcare Advocate is authorized to contact and obtain information from the individual(s) and/or facility(-ies) listed below. Be sure to include any medical providers, hospitals, family members you would like to be able to discuss your case. Use additional pages if necessary, with each provider initialed by you.

| | | |
|---|---|---|
| **The Office of the Healthcare Advocate** | ☑ Release Information | ☑ Receive Information |
| **All Insurers listed in Section II** | ☑ Release Information | ☑ Receive Information |
| John Smith | ☑ Release Information | ☑ Receive Information |
| Pamela Smith | ☑ Release Information | ☑ Receive Information |

| **Provider/Hospital Name** | **Complete Address** | **Phone** |
|---|---|---|
| Acme Hospital | 123 Hill Street, Hartford, CT | 860-555-8976 |
| Dr. Alfred Newmann | 123 Hill Street, Hartford, CT | 860-555-6363 |
| | | |
| | | |

**IV. Purpose of this Release of Information:** The purpose of this Release of Information is: *(you **must** check one)*

☑ At the request of the covered individual/legal representative ☐ For the purpose stated in the box below

☒ **I hereby agree that the Office of the Healthcare Advocate shall act as my authorized representative for the purposes of submitting all necessary appeals with my insurance company.**

If not previously revoked, this authorization **will expire** one year from the signature date below, or the earliest of the following dates: *(you **must** check one)*

□ the date the individual's coverage ends; or

■ upon the following date, event or condition Resolution of the denial of surgery

**V. Signature:** A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original. A copy of this authorization will also serve as the original if multiple disclosures are required. I understand that if this information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my information described above may be re-disclosed by the recipient and no longer protected by federal privacy regulations. This authorization is subject to revocation at any time upon written notice to the person(s)/company(-ies) specified above except to the extent that the person(s)/company(-ies) have already taken action on the disclosure provisions contained in this document. This authorization indicates your approval to release the protected health information obtained in connection with this authorization to the State of Connecticut Insurance Department for regulatory purposes.



_____ _____

Signature of member/parent on behalf of minor, as applicable Date

_____ _____

Signature of Legal Representative, if applicable Date

***PLEASE NOTE*: OHA must receive the form with your physical signature (not typed or electronic).**

If you are signing this authorization as the legal representative of an individual, we **must have a copy of the form(s)** verifying your right to authorize the disclosure of protected health information and to view such information

In addition to the protections from disclosure listed throughout this document / authorization form, any information released to the Office of the Healthcare Advocate (OHA) by authorized persons is subject to the following notices:

**Psychiatric Information:**

In the event that information released to OHA constitutes confidential psychiatric information protected under Connecticut law: This information has been disclosed to OHA from records whose confidentiality is protected by state law. State law prohibits OHA from making further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law.

**Drug and Alcohol Abuse Information:**

In the even that information released to OHA is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations: This information has been disclosed to OHA from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit OHA from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as other permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient

**HIV-Related Information:**

In the event that information released to OHA constitutes confidential HIV-related information protected under Connecticut law: This information has been disclosed to OHA from records whose confidentiality is protected by state law. State law prohibits OHA from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose.

Revised 4/19/17

**APPOINTMENT OF REPRESENTATIVE: To be completed only if your case involves Medicare.**

| Name of Beneficiary | Medicare Number |
|---|---|
| Mark Smith | 123-45-6789 |

## SECTION I: APPOINTMENT OF REPRESENTATIVE (To be completed by the Medicare Beneficiary)

I appoint this individual: Office of the Healthcare Advocate - to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to illicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

| Signature of Beneficiary | | Date |
|---|---|---|
| {{The Medicare member or legal representative needs to sign}} | | 01/01/2017 |
| **Street Address**<br>123 Main Street | | **Phone Number (with Area Code)**<br>860-555-1234 |
| **City**<br>Anytown | **State**<br>CT | **Zip**<br>06000 |

## SECTION II: ACCEPTANCE OF APPOINTMENT (To be completed by the Representative)

I, DO NOT COMPLETE THIS SECTION hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the beneficiary's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a/an: *(Please indicate the professional status / relationship to the Medicare Beneficiary, e.g., Staff, Attorney, Relative, etc.)*
☒ OHA Employee ☐ Attorney ☐ Relative: _____ ☐ Other: _____

| Signature of Representative | | Date |
|---|---|---|
| | | |
| **Street Address**<br>PO Box 1543 | | **Phone Number (with Area Code)**<br>(866) 466 - 4446 |
| **City**<br>Hartford | **State**<br>CT | **Zip**<br>06144 |



## SECTION III: WAIVER OF FEE FOR REPRSENTATION

**Instructions:** This form should be filled out if the representative waives a fee for such representation.

(**Note:** Providers or Suppliers may not charge a fee for representation and thus, all providers or suppliers that furnished items or services as issue **must** complete this section.)

I, _____, waive my right to charge and collect a fee for representing _____before the Secretary of the Department of Health and Human Services.

OHA STAFF SIGNATURE _____ DATE _____

Duplicated from the Department of Health and Human Services Centers for Medicare & Medicaid Services | Form Approved OMB No. 0938-0950
Form CMS-1696 (07/05) | EF (07/05)