Office of the Healthcare Advocate
STATE OF CONNECTICUT

Authorization for Use and Disclosure of Protected Health Information
Instruction Sheet

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

SECTION 1: CONSUMER INFORMATION (complete name, address, phone number(s), e-mail address, and date of birth) for:

1. **Member or Patient** - the person who is seeking or received the health care services at issue
2. **Personal Representative** - the person who is authorized to act on behalf of the member or patient (for example: parent/guardian, Power of Attorney, etc.)

PLEASE NOTE: If this case is related to a **minor child who received certain treatment without parental consent (for example, mental health or substance use treatment), the child is required to sign** this release in order to authorize the disclosure of the child's mental health, substance use or other similar records.

SECTION 2: INSURANCE INFORMATION - Complete information will help us resolve your matter more quickly.

1. Insurance cards: In addition to completing the form, please also provide copies of all insurance card(s) (front and back)
2. Complete the information about your health insurance (including Medicare, Medicaid/Husky, Tricare, etc.). Please provide the name and phone number of the insurance carrier or health plan administrator, the Member/Patient ID, the policyholder's name (if different from the Member/Patient), the policyholder's relationship to the Member/Patient (if applicable - for example, self, parent, spouse, etc.) and the name of the Plan Sponsor who is providing your health plan (if applicable – for example, employer, union or association).
3. If there is more than one health insurance plan, please provide information for all plans. Use a separate page, if necessary.
4. **MEDICARE BENEFICIARIES – If you have Medicare, you MUST complete a separate Medicare Appointment of Representative form, which will be provided to you in addition to this authorization form.**

SECTION 3: PROTECTED HEALTH INFORMATION TO BE DISCLOSED:

1. YOU MUST describe what health information you are authorizing for release and receipt by OHA. It is important to capture as much information as possible that is **related** to the case. Please identify records as medical records, insurance records, billing records, etc., as appropriate. Include all dates of service, services received, diagnoses, etc., when possible. If applicable, also check the appropriate boxes for specific types of records you authorize for release. Note that the information described in the boxes may be subject to special rules with respect to its disclosure and redisclosure.
2. Information will be shared with Beacon Health Options/DCF/VCMP/Solnit only if this matter relates to the DCF Voluntary Case Management Program (VCMP).
3. 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 supplemental page and initial and date each entry.
4. If you want OHA to share information and records or discuss your case with a third party, including spouse, parent, significant other, or other representative, identify the third party in the boxes provided.

SECTION 4: PURPOSE OF RELEASE:

1. **Purpose:** You must check one option, and if "For the purpose stated in the box below" is selected, be sure to specify the reason in the box provided.
2. **Authorization:** This is selected automatically, and grants OHA the authority to submit any required appeals on your behalf.
3. **Expiration:** If you do not elect a date, event or condition, the authorization will expire one year from the date of the signature on the release form. Many individuals insert as a condition: "at the completion of the case."

SECTION 5: SIGNATURE – Provide a hand-written signature; typed or electronic signatures may be rejected by some entities.
Please sign and date the form and include a copy of any power of attorney or other applicable document if you are acting as the personal representative on behalf of someone who is not your child or who is incapacitated. If the case involves behavioral health, substance use or other treatment to which a minor child consented, **it is important that the minor child sign the release in the space provided.**

SECTION 6: DEMOGRAPHIC INFORMATION - SEE PAGE 4 FOR COMPLETE INSTRUCTIONS

If you have completed this form online, please print, sign and return completed form: by email to healthcare.advocate@ct.gov; by fax to (860) 331-2499; or by mail to Office of the Healthcare Advocate, P.O. Box 1543, Hartford, CT 06144-1543.

Office of the Healthcare Advocate
STATE OF CONNECTICUT

Please complete and return with a copy of the front/back of insurance card(s)

Mail: Office of the Healthcare Advocate
P.O. Box 1543
Hartford, CT 06144-1543

Fax: (860) 331-2499

E-mail: Healthcare.Advocate@ct.gov

Authorization for Use and Disclosure of Protected Health Information

SECTION 1: Member/Patient Identification *(Please provide information for the person whose personal health information will be disclosed.)*

Name: _____ Date of Birth:____/___/_____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Telephone Number: _____ □ Cell □ Home □ Work □ Other

Alternate Telephone Number: _____ □ Cell □ Home □ Work □ Other

Email Address*: _____ I would like primary communication via e-mail: □ Yes □ No

Personal Representative Authorized to Release Medical Information for Member/Patient (if different from Member/Patient):

NOTE: If the Member/Patient is a minor child, the minor child may be required to sign Section 5 of this authorization. See Page 3.

Name of Personal Representative (if any)**:** _____

Type of Personal Representative (for example, parent, Power of Attorney, etc.) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Telephone Number: _____ □ Cell □ Home □ Work □ Other

Alternate Telephone Number: _____ □ Cell □ Home □ Work □ Other

Email Address*: _____ I would like primary communication via e-mail: □ Yes □ No

I would like to receive OHA news: □ Yes □ No

SECTION 2: Insurance Information *(Please provide front and back copy of your card(s). Please use separate sheet if needed for additional insurance carriers)*

Primary Insurance (insurance company name, Medicare, HUSKY, etc.): _____

Primary Insurance Company Phone: _____ **Enrolled through Access Health CT?** □ Yes □ No

Member/Patient ID card number: _____ **Plan type, if known (HMO, PPO, POS, etc.)** _____

Policyholder's Name (if different from Patient's): _____

Relationship to Patient: _____

Plan Sponsor, if any (for example, employer, union, association, etc.): _____

Secondary Insurance (insurance company name, Medicare, HUSKY, etc.): _____

Secondary Insurance Company Phone: _____ **Enrolled through Access Health CT?** □ Yes □ No

Member/Patient ID card number: _____ **Plan type, if known (HMO, PPO, POS, etc.)** _____

Policyholder's Name (if different from Patient's): _____

Relationship to Patient: _____

Plan Sponsor, if any (for example, employer, union, association, etc.): _____

*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).

SECTION 3: Description of Protected Health Information to be released: You **must** describe briefly **in the box** below what information you are authorizing to be released. Describe the type of information to be released (for example, claims information, billing records, medical records including test results, etc.) and where applicable, include the date(s) of service (for example, claims for the last 6 months, records for January 2020 admission, etc.) **Use a separate sheet if necessary.**

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 ☐ Abortion*
☐ Sexual/Physical/Mental Abuse* ☐ Sexually Transmitted /Other Communicable Disease* ☐ Alcohol/Substance Abuse*

***Please see page 3 of this authorization for additional notifications regarding the disclosure of mental health records, alcohol/substance abuse records HIV/AIDS-related information, records related to testing/treatment of STDs and records regarding abortion services. In addition, if you want to authorize the use or disclosure of psychotherapy notes (i.e., notes documenting contents of conversations during private, group, joint or family counseling sessions and that are separated from the rest of your medical records), an additional form may be required.**

The Release and Receipt of Health Information:

The Office of the Healthcare Advocate is authorized to contact the individual(s), organization(s) and/or facilities listed below to obtain and release the information described above.

[NOTE: Be sure to identify any medical providers, hospitals, family members or others with whom you would like OHA to discuss your case. Use additional pages if necessary, with each provider initialed and dated by you.]

Persons & Organizations Authorized to Release Information to and Receive Information from OHA	
CT Department of Insurance (if applicable)	✔
All Insurers listed in Section 2	✔
Beacon Health Options/ DCF / VCMP / Solnit (if applicable)	✔

Physicians/Hospitals/Other Health Care Providers

Name	Complete Address	Phone

Other Individuals or Organizations (family members, legal representatives, etc.)

Name	Complete Address	Phone

SECTION 4: 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

Appointment of Authorized Representative

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

Expiration of Authorization

If not previously revoked, this authorization **will expire** one year from the signature date below, or upon the following date, event or conditions: _____

SECTION 5: Signature: A copy of this authorization is available to me or to my authorized representative upon request and will serve as the original. I understand that my signature on this authorization is not a condition for any covered entity to provide any treatment, payment, enrollment in a health plan or eligibility for benefits. 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)/companies specified above, except to the extent that the person(s)/companies have already taken action on the disclosure provisions contained in this document. This authorization further indicates my approval to release the protected health information obtained in connection with this authorization to the Connecticut Insurance Department for regulatory purposes.

[**PLEASE NOTE:** If this case is related to a minor child who consented on his or her own behalf to receive mental health, substance abuse, HIV or STD testing/treatment or abortion services, the child is required to sign.]

_____ _____

Signature of Member/Patient Date

_____ _____

Signature of **Minor Child**, if applicable (see instructions) Date

_____ _____

Signature of Parent or Legal Representative, if applicable Date
(for example, Power of Attorney, Conservator, etc. – please enclose copy)

***PLEASE NOTE*: OHA requests that you sign this form with your physical handwritten signature (typed or electronic signatures may be rejected by some entities).** In addition, if you are signing this authorization as the legal representative of another individual, **please submit a copy of the document(s)** that gives you the power to authorize the disclosure of protected health information and to view such information on behalf of the other individual (for example, Power of Attorney, Appointment of Estate Fiduciary, etc.).

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 event 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. (see C.G.S. §19a-583 & §19a-585)

PLEASE COMPLETE THIS FORM FOR THE MEMBER OR PATIENT, NOT THE SUBSCRIBER OR PERSONAL REPRESENTATIVE

OHA may at times be the recipient of certain federal grants that require our office to collect certain demographic information. Such demographic information may include data regarding ancestry or ethnic origin, ethnicity, race, primary language, marital status, employment, income, and veteran status of the **Member or Patient** we are serving. We use this information to report aggregate demographic information of our consumers for purposes of complying with state and federal rules and contract/grant funding requirements. This information is used solely for such reporting and compliance purposes and will not be further shared with any person or entity without the Member or Patient's consent. OHA's services are available to all Connecticut residents and participants in Connecticut health plans and **OHA does not discriminate against any individual on the basis of the demographic categories or classes identified on this form.** You are not required to complete this form in order to receive services from OHA.

SECTION 6. – Requested demographic information specific for the individual receiving OHA assistance

How Member/Patient HEARD ABOUT OHA:

□ Access Health □ Attorney □ Broker □ Church □ Community Advocate □ Denial Letter from Insurer □ Employer
□ Federal Agency _____ □ Governor/Lt. Governor's Office □ Health Plan □ Info Line (211) □ Internet Search
□ Legislator _____ □ Media-Radio □ Media-TV □ OHA Outreach Event □ Personal Referral □ Previous Case
□ Provider □ Senior Center/Town □ Social Media □ State Agency_____ □ Other: _____

Member/Patient ETHNICITY: (select all that apply)

☐ Hispanic/Latino/a/Spanish
☐ Argentinian ☐ Chilean ☐ Colombian ☐ Cuban ☐ Dominican ☐ Ecuadorian ☐ Guatemalan ☐ Honduran
☐ Mexican, Mexican American, Chicano/a ☐ Nicaraguan ☐ Panamanian ☐ Peruvian ☐ Puerto Rican ☐ Salvadoran
☐ Spaniard ☐ Spanish ☐ Uruguayan ☐ Venezuelan ☐ Other Spanish _____
☐ Not Hispanic/Latino/a/Spanish
☐ Other _____
☐ I decline to identify

Member/Patient RACE: (select all that apply)

☐ American Indian or Alaska Native
☐ Alaska Native ☐ Cherokee ☐ Iroquois ☐ Mashantucket Pequot ☐ Mohegan
☐ Other American Indian/Alaska Native: _____
☐ Asian
☐ Asian Indian ☐ Bangladeshi ☐ Burmese ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Hmong ☐ Indonesian
☐ Japanese ☐ Korean ☐ Laotian ☐ Malaysian ☐ Nepalese ☐ Pakistani ☐ Sri Lankan ☐ Taiwanese
☐ Thai ☐ Vietnamese ☐ Other Asian: _____
☐ Black or African American
☐ Black or African American ☐ African ☐ African American ☐ Dominican ☐ Haitian ☐ Jamaican
☐ West Indian ☐ Other: _____
☐ Native Hawaiian or Other Pacific Islander
☐ Guamanian or Chamorro ☐ Native Hawaiian ☐ Samoan ☐ Other Pacific Islander: _____
☐ White
☐ Arab ☐ European ☐ Middle Eastern or Northern African ☐ Portuguese
☐ Some Other Race: _____
☐ I decline to identify

Member/Patient PRIMARY LANGUAGE:

How well do you speak English? ◯ Very Well ◯ Well ◯ Not Well ◯ Not at all ◯ I decline to identify
Do you speak a language other than English at home? ◯ Yes ◯ No
If yes, what is the language? ☐ Spanish ☐ Other Language _____ ☐ I decline to identify

Member/Patient MARITAL STATUS:

□ Single □ Married □ Civil Union □ Separated □ Divorced □ Domestic Partner □ Widowed □ Child

Member/Patient MILITARY STATUS:

Have you ever served in the military? ◯ Yes ◯ No ◯ Decline to answer

Are you eligible for veteran healthcare benefits? ◯ Yes ◯ No ◯ I don't know

Member/Patient EMPLOYMENT STATUS:

□ Full-Time employed, one job
□ Full-Time employed, more than one job
□ Part-time Employed
□ Not working, Disabled
□ On Leave
□ Retired
□ Unemployed, looking for work
□ Unemployed, not looking for work
□ Student/Minor

Member/Patient INCOME SOURCES:

□ Wages
□ Pension/Retirement
□ SSI
□ SSDI
□ Child Support
□ None
□ Other _____

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved OMB No.0938-0950

Appointment of Representative

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, _____, 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 elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____ 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 (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an employee of the Office of the Healthcare Advocate, State of Connecticut _____
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address P.O. Box 1543		Phone Number (with Area Code) 866-466-4446
City Hartford	State CT	Zip Code 06144
Email Address (optional)		

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and must complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.) I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

Charging of Fees for Representing Beneficiaries before the Secretary of HHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation

Approval of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before HHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before HHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance or complaint if you are filing a grievance or complaint, or an initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact 1-800-MEDICARE (1-800-633-4227) or your Medicare plan. TTY users please call 1-877-486-2048.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you believe you've been discriminated against. Visit https://www.cms.gov/about-cms/agency-Information/aboutwebsite/cmsnondiscriminationnotice.html, or call 1-800-MEDICARE (1-800-633-4227) for more information.
