Authorization For The Use And Disclosure Of Individually Identifiable Health Information

I hereby authorize the use or disclosure of my individually identifiable health information by The Health Plan as described below. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

1. Specific description of information that may be used/disclosed:
   - ☐ Eligibility Information
   - ☐ Claims Information
   - ☐ Medical Information
   - ☐ Other: _____

2. The information will be used/disclosed for the following purpose(s):
   - ☐ At the request of the individual
   - ☐ Other: _____

3. Persons/organizations authorized to use or disclose the information.

   I authorize The Health Plan of West Virginia, Inc. to release the information described above to:

Authorized Person's Information:	**Authorized Person's Information:**
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
_____	_____
Phone number: _____	Phone number: _____
Relationship: _____	Relationship: _____

4. The person/organization authorized to use or disclose this information will receive compensation for doing so. ☐ Yes ☐ No

5. I understand that I have the right to:
    - Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
    - Refuse to sign this authorization. Such refusal will not affect eligibility for benefits or enrollment, payment or coverage of services, or ability to obtain treatment, except as provided in numbers 6 and 7 below.

6. If the purpose of this authorization is for The Health Plan to determine eligibility before enrollment and is not for psychotherapy notes and I refuse to sign this authorization, The Health Plan reserves the right to deny enrollment or eligibility for benefits.

7. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain that information, and I refuse to sign this authorization, The Health Plan reserves the right to deny that health care.

8. I understand that I may revoke this authorization at any time by notifying The Health Plan in writing, except to the extent that:
    - Action has been taken in reliance on this authorization; or
    - If this authorization is obtained as a condition of obtaining coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

9. I understand that I have a right to request and receive a Notice of Privacy Practices from The Health Plan.

10. This authorization shall be in force and effect until:
    - ☐ List Specific Date: _____
    - ☐ List Expiration Event: _____

If no date or event is entered, the authorization will expire a year from signature date below.

_____ _____

Signature of Individual Date

Member's THP ID Number: _____

Name of subscriber (if applicable): _____