Pharmacy Benefit Dimensions

Authorization to Disclose Protected Health Information (PHI)

Under Federal and State privacy laws, Independent Health's Pharmacy Benefit Dimensions, LLC ("Pharmacy Benefit Dimensions" or "PBD"), Independent Health Association, Inc. ("IHA") and its affiliates, is authorized to use or disclose your health information for payment, treatment and health care operations and as required by law. For uses and disclosures other than these purposes, your written authorization is required before sharing your health information. This includes sharing your health information with your spouse, relatives, employer, etc. This form allows you to authorize PBD to use or disclose your health information including HIV-related information to those individuals or entities you specify.

Please read before completing this form

- Incomplete authorizations will be considered invalid and will not be accepted. Incomplete authorizations will be returned. **An asterisk (*) is used to denote the required fields in this form.**
- Completion of this authorization form is voluntary. You may refuse to sign this form, but then PBD will not be able to release your information.
- A copy of this authorization will be available to you, but you should retain a copy for your records.
- Signing or not signing this form will not affect any payment, enrollment or eligibility for benefit decisions made by PBD.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described in this authorization may be disclosed to other individuals or institutions and no longer protected by these regulations.
- You may revoke this authorization in writing at any time by sending PBD a letter to the address listed below. Your revocation notice will not apply to actions taken by the requesting person/entity prior to the date we received your written request to revoke this authorization.

Send completed and signed authorization to:

Pharmacy Benefit Dimensions
P.O. Box 1642
Buffalo, NY 14231
Fax: (716) 250-7139
servicing@pbdrx.com

If you need assistance completing this form, please contact:

PBD Medicare Member Servicing

(716) 504-4444
1-800-667-5936
(TTY users call 711)

Pharmacy Benefit Dimensions

Authorization to Disclose Protected Health Information (PHI)

Section A: Member Information*		
Name*:	**Date of Birth*:** / /	**Member ID*:** __ __ __ __ __ __ __ __ __ - __ __

Section B: Authorized Individuals* (at least one individual is required)
Please list the individuals and/or entities that you are authorizing to view or receive your health information. If more space is required to list individuals or entities, please attach an additional page.

1.	**Name*:**	**Relationship*:**	**Telephone Number*:** ( )
2.	**Name:**	**Relationship:**	**Telephone Number:** ( )
3.	**Name:**	**Relationship:**	**Telephone Number:** ( )

Section C: Information That Can Be Released (Select C-1 or C-2 and if applicable, C-3)*
If more space is needed to describe the information that can be released, please attach an additional page.

☐ **C-1:** I would like you to disclose any of my health information requested by the individuals and/or entities named in Section B. This does **not** include information in Part C-3 (below) unless I have placed my initials next to the condition. If I do not place my initials in C-3, information related to those conditions will not be disclosed.

- OR -

☐ **C-2: Only the following specific health information** (such as claims submitted by a specific provider or information related to one of the protected diagnoses listed below):

_____

_____

_____

- AND, IF APPLICABLE -

C-3: Unless specifically initialed below, I understand my health information will not be disclosed related to the following conditions. By placing my initials next to one or more of these conditions, I am authorizing PBD to disclose information related to the condition(s) (see page 4 for additional information):

_____ Alcohol and/or Substance Abuse

_____ HIV-Related

_____ Pregnancy/Reproductive

_____ Mental Health

_____ Sexually Transmitted Diseases

_____ Genetic Testing

Section D: Purpose and Time Period

Unless noted below, the authorized parties in Section B can obtain your health information upon their request and from the start date of your plan coverage with PBD.

☐ Purpose: _____

☐ Time Period: Only release health information concerning dates of service from (*insert date*) _____ to (*insert date*) _____.

Section E: Expiration

This authorization will automatically expire one (1) year after termination of your enrollment, upon your death, in the case of a minor, when the named minor reaches the age of eighteen (18) years, or if PBD receives a letter from you revoking this authorization.

For dates or events not described in the preceding paragraph, you may specify an expiration date or event for this authorization below:

This authorization will expire:

☐ On the following date (*insert date*): _____

☐ On the following event: *(please specify)* _____

Section F: Personal Representative Information

Complete this section if you are a personal representative that is acting on behalf of a member. <u>You must include a copy of one of the following documents</u> as proof of your legal representation and authority:

□ Valid health care proxy
□ Certificate of guardianship issued by a New York State Supreme or Surrogate Court
□ Surrogate decision maker appointed pursuant to Family Health Care Decisions Act (FHCDA)

If the member is deceased, please submit a copy of one of the following:
□ Letters of Administration or Letters Testamentary

Name:	**Relationship:**	**Telephone Number:** ( )

Section G: Signature/Date*

Please read the following carefully before you sign, and refer to page 4 for additional information.

By signing this form, I understand the following: (1) if the entity authorized to receive my health information is not a health plan, health care provider or other covered entity as described by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, the released information may no longer be protected by federal privacy laws, rules and regulations; (2) the information disclosed will only include mental health, alcohol and substance abuse, HIV-related information, sexually transmitted disease, pregnancy and reproductive and/or genetic testing information if I specifically direct PBD to release that information; (3) I am not required to sign this form, but if I do not sign this form, it will not be considered valid, it will be returned to me and no information will be released by PBD; (4) I may revoke this authorization at any time by notifying PBD in writing; (5) if I do revoke this authorization, my revocation will have no effect on any actions PBD took according to this authorization before PBD received my revocation; and (6) it is my choice whether I sign this form and signing or not signing this authorization will not affect any payment, enrollment, or eligibility for benefit decisions made by PBD.

☐ By checking this box, this form replaces any HIPAA authorization forms previously sent to PBD.

I sign this authorization under penalty of perjury and attest that the information contained in this authorization is true and correct and may be relied upon by PBD.

_____ **Date:** _____

Signature of Member or Personal Representative

Sensitive Information

- **Alcohol and Substance Abuse Information**
  By initialing the appropriate box on this form, alcohol and substance abuse information can be provided to the individuals listed by you on this form. If information is disclosed from alcohol or substance abuse records protected by federal confidentiality rules (42 CFR Part 2), these rules prohibit the recipient 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 otherwise permitted by these rules.

- **HIV-Related Information**
  By initialing the appropriate box on this form, HIV-related information can be provided to the individuals listed by you on this form. HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

  Under New York state law, HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; authorized agencies involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood; special court order; attorney assigned to represent a minor or by an executor or administrator of an estate (Public Health Law §2782). Under state law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of medical and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

- **Pregnancy and Reproductive Information**
  By initialing the appropriate box on this form, information relating to pregnancy and reproductive health can be provided to the individuals listed by you on this form. Information regarding pregnancy and reproductive health cannot be disclosed, even to a parent or guardian of a minor patient, without the specific authorization of the patient (Public Health Law §17).

- **Mental Health Information**
  By initialing the appropriate box on this form, mental health information can be provided to the individuals listed by you on this form. Mental health information, including a patient's clinical records and information can be released, with your consent or the consent of someone authorized to act on your behalf, to those authorized agencies listed by you on this form who have a demonstrable need for such information provided such disclosure will not reasonably be expected to be detrimental to you or others (Mental Hygiene §33.13).

- **Sexually Transmitted Diseases**
  By initialing the appropriate box on this form, information regarding sexually transmitted disease can be provided to the individuals listed by you on this form. Parents may access most of their child's medical records until the child turns 18, with the exception of information relating to the diagnosis and treatment of sexually transmitted disease (Public Health Law §17). Such information cannot be released to any party, including the child's parent or guardian, without the child's specific authorization.

- **Genetic Testing**
  By initialing the appropriate box on this form, genetic testing information can be provided to the individuals listed by you on this form. Genetic testing information includes any information relating to laboratory tests of human DNA, chromosomes, genes or gene products to diagnose a predisposition to a genetic disease of disability in the individual or offspring (Civil Rights Law §79-l). Genetic testing information shall not be released without your specific consent with the exception of information released to a health insurer or health maintenance organization for the purpose of claims administration.

Instructions for Completion of Authorization to Disclose Protected Health Information (PHI)

Section A: Enter your name, date of birth, and your member ID number including your suffix

Section B: List the name, relationship, and telephone number for the individuals and/or entities that you are authorizing to view or receive your health information.

Section C: Choose either Box C-1 **OR** box C-2 **AND** initial C-3 if applicable.

- **Box C-1:** Select this box to permit all of your health information to be disclosed. Please note, checking this box alone does NOT include the sensitive conditions listed in C-3, which you must separately initial in C-3.

- **Box C-2:** Select this box to limit the health information that you wish to be disclosed. You should write in the specific information you are authorizing to be disclosed and be as detailed as possible. Please note, checking this box alone does NOT include the sensitive conditions listed in C-3, which you must separately initial in C-3 or manually write in here.

- **Box C-3:** If you wish for any of these sensitive conditions to be disclosed, you must initial them individually here.

Section D: You may leave this section blank to default to the purpose and time period rules as indicated on the form, or you may specify a different purpose and/or time period.

- **Purpose:** The circumstances in which you are authorizing the information to be disclosed. For instance, you may choose to list a narrow purpose such as litigation or claim payment resolution. If left blank, your representatives may obtain your information upon their request.

- **Time Period:** The scope of the information to be released. For instance, you may choose to list a specific time frame such as 1/01/2021-12/31/2021. If left blank, your representatives may obtain your information from the start date of your plan coverage with PBD.

Section E: This form will expire automatically upon the events noted on the form, but you may specify additional dates or events that would trigger the form to expire, such as upon your death or listing a specific date.

Section F: If you are a personal representative that is acting on behalf of a member in signing this authorization, please check which authority you hold and include a copy of the relevant document(s) as proof of your legal representation and authority. Please list your name and telephone number as well as relationship to the member.

Section G: Please sign and date the form in this section, whether you are filling it out for yourself or on behalf of the member. As a reminder, if you are signing on behalf of the member, please include a copy of the relevant document(s) as proof of your legal representation and authority. If you wish this form to replace previous HIPAA Authorization forms on file with PBD, please check the box in this section.

Language Assistance Services

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-667-5936 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-667-5936 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-667-5936（TTY：711）。
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-667-5936 (телетайп: 711).
French Creole	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-667-5936 (TTY: 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-667-5936 (TTY: 711) 번으로 전화해 주십시오.
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-667-5936 (TTY: 711).
Farsi	**توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-667-5936 (TTY: 711) تماس بگیرید.
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-667-5936 (TTY: 711).
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-667-5936 (TTY: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، إن المساعدة خدمات اللغوية المجانية متوافرة لك. اتصل برقم 1-800-667-5936 (رقم الصم والبكم: 711).
French	ATTENTION : Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-667-5936 (TTY : 711).
Portuguese	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-667-5936 (TTY: 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-667-5936 (TTY: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-667-5936（TTY: 711）まで、お電話にてご連絡ください。
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-667-5936 (TTY: 711).

Pharmacy Benefit Dimensions®

Discrimination is Against the Law

Pharmacy Benefit Dimensions is a subsidiary of Independent Health and complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Pharmacy Benefit Dimensions does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Pharmacy Benefit Dimensions:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Pharmacy Benefit Dimensions' Member Services Department.

If you believe that Pharmacy Benefit Dimensions has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Pharmacy Benefit Dimensions' Member Services Department, P.O. Box 1642, Buffalo, NY 14231, 1-800-667-5936, TTY users call 711, fax (716) 250-7163, PBDMedicareservicing@pbdrx.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Pharmacy Benefit Dimensions' Member Services Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200
Independence Avenue, SW
Room 509F, HHH Building Washington,
D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.