



**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 of West Virginia, Inc. (THP) 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.

<b>Released From:</b>	<b>Released To (must specify person or entity):</b>
The Health Plan of West Virginia	Name:
1110 Main Street	Address:
Wheeling, WV 26003	
1.800.624.6961	Phone Number:

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 or 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 THP to determine eligibility before enrollment and is not for psychotherapy notes and I refuse to sign this authorization, THP 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, THP reserves the right to deny that health care.
  8. I understand that I may revoke this authorization at any time by notifying THP in writing, except to the extent that:
    - Action has been taken in reliance upon 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 THP.
  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 one year from signature date below.*

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Date

Member's THP ID Number: \_\_\_\_\_

Name of subscriber (if applicable): \_\_\_\_\_

If the above signature is that of a personal representative, THP has verified the identity of the representative.

