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.

1. **Specific description of information to be used/disclosed:**

Information Requested		**Time Period (if applicable)**	
☐	Eligibility Information	from	to
☐	Claims Information	from	to
☐	Medical Information	from	to
☐	Other: _____	from	to

2. I understand that that this authorization may include disclosures of mental health records, HIV/AIDS information, sexually transmitted disease information and substance use treatment records.

3. **The information will be used/disclosed for the following purpose(s):**

   ☐ At the request of the individual

   ☐ Other: _____

4. **Persons/organizations authorized to use or disclose the information.**

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

5. **This authorization shall be in full force and effect until:**

   ☐ List Specific Date: _____

   ☐ List Expiration Event: _____

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

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

7. 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.

8. 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 9 and 10 below.

9. If the purpose of this authorization is for THP to determine eligibility before enrollment and I refuse to sign this authorization, THP reserves the right to deny enrollment or eligibility for benefits.

10. 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.

11. I understand that I may revoke this authorization at any time by notifying THP in writing, except to the extent that actions have already been taken in reliance of this authorization or when the authorization was obtained as a condition of obtaining insurance coverage with THP.

12. I understand that I have a right to request and receive a Notice of Privacy Practices from THP.

Please print the following information:

Member Name:		
Address:		
City:	State:	Zip Code:
Date of Birth:	Plan ID Number:	
Phone Number:	Email Address:	
Member Signature:		Date:
Legal Representative Signature: *(if applicable)*		Date:
Relationship to Member:		

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