City of Mesa Health Plan

Protected Health Information (PHI) - Authorization for Release Form

EMPLOYEE INFORMATION (Print)	
Name (First - Last):	Employee/Member ID #:

I, _____ hereby designate _____ to receive the
EMPLOYEE/MEMBER/PATIENT NAME REQUESTING PHI RELEASE — PERSON NAME & RELATIONSHIP, OR ORGANIZATION TO RECEIVE PHI INFORMATION

following type of Protected Health Information (PHI) on my behalf:

(Please Initial)

1. ☐ All Health Information (including medical, dental, prescription drug, psychiatric/psychological records and clinical session notes).
2. ☐ All Health Information (including medical, dental, prescription drug, but **NOT** including psychiatric/psychological records and clinical session notes).
3. ☐ All Health or Dental Information of the following treatment, condition or date of treatment: _____
   _____
4. ☐ Other: _____

Type of PHI to be disclosed: eligibility and coverage information; utilization management authorizations e.g. pre-certifications, concurrent review, case management and disease management; claims administration details including date of service, billed amount, treating provider name, procedure codes/descriptions, diagnosis codes/descriptions, clinical pysch session notes, claim type, accumulator information, co-payment or co-insurance amounts, covered expenses, claim payment amount, denied expenses, appeal processes and decisions.

Purpose(s) for which disclosure of PHI will be limited: plan benefit information including verification of eligibility and coverage; claims administration for the benefit of the participant in the form of claim status, claim payment status, claim processing details and claim appeal status/decisions.

Persons/organizations providing PHI disclosure: City of Mesa Health Plan Administration authorized representatives and/or authorized representatives of any contracted third party administration organizations.

I understand:

- Signing this Authorization is not a prerequisite to my participation in the City of Mesa Health Plan
- The information that is used or disclosed under this Authorization may be re-disclosed by the receiving entity(s) for the specific purposes authorized
- This Authorization will expire 12 months after the termination of my participation in the Plan if not previously revoked by me
- I may revoke this Authorization at any time by completing and submitting an Authorization to Revoke Protected Health Information Disclosure Form

I certify that I have read and understand this PHI Authorization, and that the information in it is true and correct.

Signature of Member/Patient Requesting PHI Release of Information:	Date: