Authorization for Use and Disclosure of Private/Protected Health Information
Instruction Sheet

In order for OHA to advocate for you, this form must be complete and accurate. Please review and follow the instructions below, and contact the office at (866) 466-4446 with any questions about this release.

SECTION I: CONSUMER INFORMATION

1. Complete the name, address, phone number(s), e-mail address, gender, and date of birth for the **"Subscriber",** which is the person who obtained the primary insurance policy (e.g., spouse on the spouse's plan).
2. Complete the name, address, phone numbers(s), e-mail address, gender and date of birth for the **"Member or Patient"**, which is the person who is having the issue that you contacted us about.

PLEASE NOTE: If this case is related to a child **age 14 or older, with mental health or substance use issues, the child is required to sign** a separate release authorizing release of mental health or substance use records.

SECTION I-A: DEMOGRAPHIC INFORMATION – This should be completed for the Member, not the Subscriber

OHA receives federal grants, therefore we are required to collect information on ethnicity, race, marital status, employment, income and veteran status of the **"Member or Patient"** we are serving. We use this information to report on the demographic information of our consumers only. This information is not readily shared.

Section II: INSURANCE INFORMATION - Failure to provide information regarding all insurance may delay resolution of your issue.

1. Insurance cards: provide a copy of your card(s) (front and back)
2. Complete this section with the information about your health insurance or Medicaid to fill in the name and address of the insurance company, subscriber ID and group number, employer's name, employee's name and the relationship to the **"Member or Patient"** (e.g., self, mother/father, spouse, etc.) If you have more than one type of insurance, please complete that information for each, and use a separate sheet of paper if necessary. We collect your employer name to help us determine what kind of healthcare coverage you have.

SECTION III: PRIVATE HEALTH INFORMATION FOR RELEASE

1. YOU MUST describe what health information you authorize for release and receipt. It is important to capture as much information as possible that is **related** to the case. Please include all dates of service, services received, diagnosis, etc. You should also check next to any specific record types you authorize us to obtain. Please note the special instructions for certain categories of records in this section.
2. Include any additional parties who you authorize to release or receive your health diagnosis and/or insurance information.
3. If you wish us to share information or discuss your case with a spouse, parent or significant other, this must be included on a line under "The Office of the Healthcare Advocate."
4. List the hospitals, doctors and/or providers who have the necessary medical information and whom we may contact. Include the address and phone numbers for each facility/provider.

If necessary, please list additional providers on a separate page, and **initial and date** all hospitals/providers listed on this page.

Please note that the State of Connecticut regulates fully insured plans. These plans include individual insurance plans and certain group plans, including small group plans.

SECTION IV: PURPOSE OF RELEASE

1. **Purpose**: You must check one option, and if "For the purpose below" is selected, be sure to specify the reason in the section provided; **Authorization**: This is selected automatically, and grants OHA the authority to submit any required appeals on your behalf; **Expiration**: You must select one option and complete area requiring additional information. Many individuals choose the last option and write/type in "at the completion of the case".

SECTION V: SIGNATURE

1. Please sign and date the form and include a power of attorney or other applicable document if you are acting on behalf of someone who is not your child or who is incapacitated. **It is important that the minor sign to release certain records.**

MEDICARE – If you have Medicare, you MUST complete Section I ONLY of page 5 of this release, the Medicare Appointment of Representative form

If you've completed the form online, please print it and either scan and return it by (1) email to the appropriate staff, (2) fax it to the staff's attention at (860) 622-2630 or (3) mail it to the address shown on the top of page 2.

Office of the Healthcare Advocate
STATE OF CONNECTICUT

Please complete this form and return via mail:
Office of the Healthcare Advocate
P.O. Box 1543
Hartford, CT 06144-1543

Or Fax: (860) 622-2630 **Or E-mail**: healthcare.advocate@ct.gov

Authorization for Use and Disclosure of Private/Protected Health Information

NOTE: Your enrollment in a health plan, eligibility for benefits, processing, and payment of claims, or treatment is not a condition of this authorization

SECTION I: Identification of Person Authorizing Release (*the following is needed for verification*). *Please complete all applicable items.*

Name of **Subscriber:** _____ Date of Birth: ___/___/_____

Address: _____

City: _____ State: _____ Zip Code: _____

What is your current gender identity? Man___ Woman___ Transgender Man ___ Transgender Woman___ Different Identity_____

Telephone Number(s) (H):_____ (W) _____

(C): _____ (Fax) _____

Email Address*: _____

I am the Person Authorized to Release Medical Information for: □ **SELF** (*Skip to I.A*) □ **CHILD/FAMILY MEMBER** □ **OTHER**

Name of **Member/Patient:** _____ Date of Birth: ___/___/_____

Address: _____

City: _____ State: _____ Zip Code: _____

What is your current gender identity? Man___ Woman___ Transgender Man ___ Transgender Woman___ Different Identity_____

Telephone Number(s) (H): _____ (W): _____

(C): _____ (Fax): _____

Email Address*: _____

I would like primary communication via e-mail: ____ YES ____ NO I would like to receive E-alerts from OHA: ____ Yes____ NO

Section I.A – Requested Demographic Information Specific for the Individual receiving OHA Assistance**

Member/Patient ETHNICITY. ____ Hispanic, Latino/a or Spanish ____Mexican, Mexican American, Chicano/a ___Puerto Rican ____ Cuban ____ Another Hispanic, Latino or Spanish origin

Member/Patient RACE: ____White ____Black or African American ____ Hispanic/Latino ____Asian American ___Native Hawaiian ____Indian/Native American ____Chinese ___ Guamanion or Chamorro ___Filipino ___Japanese ___ Korean ____Vietnamese ____ Other Pacific Islander ____ Samoan ____Other

How well do you speak English? ____ Very well ____ Well ____ Not Well ____ Not at all

If you speak a language other than English at home, what is the language? ____ Spanish Other Language (identify) _____

Member/Patient is: □ Single □ Married □ Separated □ Divorced □ Civil Union □ Domestic Partner □ Widowed □ Child

Member/Patient is: □ Full-Time employed (□ one job / □ two jobs / □ self) □ Part-time Employed □ Student/Minor □ Retired □ Unemployed (□ looking for work / □ not looking for work) □ Disabled / Not working □ Unknown

Member/Patient Income Source: □ Wages □ Pension/Retirement □ SSI □ SSDI □ Child Support □ Unemployment Benefits □ Self-Employed □ Other/Unknown □ None

Member/Patient heard about OHA: □ Insurance Denial □Provider/Hospital □ Media/Advertisement □ State Agency/Legislator □ Attorney/Broker □ Outreach Event □ Referral/Info Line (211) □ Federal Agency/Legislator □ Social Media/Website □ Other: _____

*OHA uses email to communicate with clients. Please be advised that our email communications are made through a secured server, which requires you to complete a one-time set-up to access the secured email(s).

**Please complete the federally requested demograpic information section; this information is used solely for aggregate reporting purposes and will not be shared with any person or entity.

II. Insurance Information *(Please provide front and back copy of your card(s). Please use separate sheet for additional insurance carriers)*

Primary Insurance Company Name: _____

Primary Insurance Company phone: _____ Enrolled through Access Health CT? □ Yes □ No

Patient Member ID card number: _____

Group or Account Number on ID card: _____ tfl·y type (HMO PPO, th{ etc.) _____

Subscriber's Employer Name: _____

Subscriber's Employee Name (if different from Member's): _____

Subscriber's Relationship to Member: _____

Secondary Insurance Company Name: _____

Secondary Insurance Company phone: _____ Enrolled through Access Health CT? □ Yes □ No

Patient Member ID card number: _____

Group or Account Number on ID card: _____ tfan type (HMO PPO, th{ etc.) _____

Subscriber's Employer Name: _____

Subscriber's Employee Name (if different from Member's): _____

Subscriber's Relationship to Member: _____

III. Description of Private Health Information to be released: You **must** describe briefly **in the box** below what information you are authorizing to be released. Describe in detail the kind of information (e.g., claims information, premium information, medical records including test results, etc.) you want released, and if applicable, the date(s) of service/information (e.g., claims for the last 6 months, premium payment record for January, etc.) **Use a separate sheet if necessary.**

In addition, if you agree that the following types of records may be released, please indicate by checking the appropriate boxes:

☐ Progress Notes ☐ Mental Health ☐ Genetic Testing ☐ HIV/AIDS * ☐ Maternity
☐ Sexual/Physical/Mental Abuse ☐ Sexually Transmitted /Other Communicable Disease ☐ Alcohol/Substay e Abuse*

***If you want to authorize the use or disclosure of other protected health information as well, an additional form must be submitted. Please see the last page of this authorization, which describes in more detail further disclosure of HIV/AIDS records and Alcohol & Substance Abuse records.**

The Release and Receipt of Health Information:

The Office of the Healthcare Advocate is authorized to contact and obtain information from the individual(s) and/or facility(-ies) listed below. Be sure to include any medical providers, hospitals, family members you would like to be able to discuss your case. Use additional pages if necessary, with each provider initialed by you.

The Office of the Healthcare Advocate	☑ Release Information	☑ Receive Information
All Insurers listed in Section II	☑ Release Information	☑ Receive Information
	☐ Release Information	☐ Receive Information
	☐ Release Information	☐ Receive Information

Provider/Hospital Name	**Complete Address**	**Phone**

IV. Purpose of this Release of Information: The purpose of this Release of Information is: *(you **must** check one)*

☐ At the request of the covered individual/legal representative ☐ For the purpose stated in the box below

☒ **I hereby agree that the Office of the Healthcare Advocate shall act as my authorized representative for the purposes of submitting all necessary appeals with my insurance company.**

If not previously revoked, this authorization **will expire** one year from the signature date below, or the earliest of the following dates: *(you **must** check one)*

□ the date the individual's coverage ends; or

□ upon the following date, event or condition _____

V. Signature: A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original. A copy of this authorization will also serve as the original if multiple disclosures are required. I understand that if this information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my information described above may be re-disclosed by the recipient and no longer protected by federal privacy regulations. This authorization is subject to revocation at any time upon written notice to the person(s)/company(-ies) specified above except to the extent that the person(s)/company(-ies) have already taken action on the disclosure provisions contained in this document. This authorization indicates your approval to release the protected health information obtained in connection with this authorization to the State of Connecticut Insurance Department for regulatory purposes.

_____ _____

Signature of member/parent on behalf of minor, as applicable Date

_____ _____

Signature of Legal Representative, if applicable Date

***PLEASE NOTE*: OHA must receive the form with your physical signature (not typed or electronic).**

If you are signing this authorization as the legal representative of an individual, we **must have a copy of the form(s)** verifying your right to authorize the disclosure of protected health information and to view such information

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In addition to the protections from disclosure listed throughout this document / authorization form, any information released to the Office of the Healthcare Advocate (OHA) by authorized persons is subject to the following notices:

Psychiatric Information:

In the event that information released to OHA constitutes confidential psychiatric information protected under Connecticut law: This information has been disclosed to OHA from records whose confidentiality is protected by state law. State law prohibits OHA from making further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law.

Drug and Alcohol Abuse Information:

In the even that information released to OHA is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations: This information has been disclosed to OHA from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit OHA 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 other permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient

HIV-Related Information:

In the event that information released to OHA constitutes confidential HIV-related information protected under Connecticut law: This information has been disclosed to OHA from records whose confidentiality is protected by state law. State law prohibits OHA from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose.

Revised 4/19/17

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved OMB No.0938-0950

Appointment of Representative

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, _____, to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 2: Acceptance of Appointment

To be completed by the representative:

I, Office of the Healthcare Advocate hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____

(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address P.O. Box 1543		Phone Number (with Area Code) 866-466-4446
City Hartford	State CT	Zip Code 06144
Email Address (optional)		

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and must complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.) I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

Charging of Fees for Representing Beneficiaries before the Secretary of HHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation

Approval of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before HHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before HHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance or complaint if you are filing a grievance or complaint, or an initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact 1-800-MEDICARE (1-800-633-4227) or your Medicare plan. TTY users please call 1-877-486-2048.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you believe you've been discriminated against. Visit https://www.cms.gov/about-cms/agency-Information/aboutwebsite/cmsnondiscriminationnotice.html, or call 1-800-MEDICARE (1-800-633-4227) for more information.
