



## INSTRUCTIONS FOR COMPLETING

### The *Authorization to Release Protected Health Information Form*

Protecting your privacy is a top priority at HealthTrust. We comply with the Health Insurance Portability and Accountability Act (HIPAA) which requires that we obtain a signed release form from you (or someone you designate to represent you) before sharing your protected health information (PHI) with others. For more information please refer to the [HealthTrust Notice of Privacy Practices](#) posted on our website.

If you want us to release your PHI – or the PHI of your child or other covered dependent – to a spouse or other family member, a medical provider, your employer, your attorney or other individual or entity, please follow the instructions below for completing and submitting the [Authorization to Release Protected Health Information](#) form. In addition to being linked here, this form is available on the HealthTrust website, [www.healthtrustnh.org](http://www.healthtrustnh.org); click on the Forms and Documents icon in the upper right corner of the homepage and scroll to Privacy and Security (HIPAA).

#### Part A: Information about the Covered Individual

1. If you are authorizing HealthTrust to release your own PHI, type or print clearly in the spaces provided: Your last name, first name, your email, your street address, apartment number (if applicable), city/town, state and ZIP Code; your phone number (including area code) and your date of birth.
  - If you are authorizing HealthTrust to release the PHI of someone else covered under your plan (such as your child or another dependent), print or type that Covered Individual's name and contact information clearly in the spaces provided.
2. Please indicate the Covered Individual's relationship to person authorizing release of PHI: Self, Parent, Spouse, Other: \_\_\_\_\_  
title or brief description
3. Type or print your name in the blank provided to indicate that you are the person who is authorizing HealthTrust to release the Covered Individual's PHI.
4. Under **"Information about the person you are authorizing to receive your information,"** print or type where indicated:
  - The recipient's last name, first name, email address, street address (including apartment number if applicable), city/town, state and ZIP Code.
  - The recipient's daytime phone number including area code in the space provided.
  - Under "Recipient's relationship to the Covered Individual," check the appropriate box. If none of the boxes apply, enter a brief description in the space provided after "Other" that includes how the person, organization or other entity relates to you.

#### Part B: Information that can be released

This section tells us what information you would like HealthTrust to release: all or just some.

Under **"I allow the following information to be released by HealthTrust on my or the Covered Individual's behalf"** you need to **select one** of two choices: all or limited information.

1. Check the first box if you would like HealthTrust to **release all** your information as described.
2. Check the second box if you want to **limit the information** that HealthTrust releases, then check the specific boxes in this section for the type(s) of information you are authorizing HealthTrust to release.

Under **“I also approve the release of the following types of sensitive information by HealthTrust,”** you have three choices:

1. Do not check any of the boxes if you do not want to release any sensitive information as described.
2. Check **“All sensitive information”** if you **DO NOT want to limit** the sensitive information you are authorizing HealthTrust to release.
3. Check **“Just information about topics checked below,”** if you **DO want to limit** the sensitive information you are authorizing HealthTrust to release. Then check the box(es) next to the specific content you are authorizing for release and/or enter the type of sensitive information after Other:\_\_\_\_\_.
4. If you have checked the box next to substance use disorder, enter the time period of substance use disorder records to be disclosed and the description of those records in the fields provided, if applicable.

### **Part C: Date your approval expires – Check only one box.**

You have two choices for when you would like this approval to end:

1. Check the first box, “Upon termination of enrollment,” if you want this authorization to continue throughout your enrollment in HealthTrust coverage.
2. Check the second box if you want this authorization to end earlier, for example, upon the settlement of a claim, or other event or condition, and describe the event on the line below.

### **Part D: Review and approval**

If you are the Covered Individual or Parent, sign your name after the “x” and add the date you are signing the document. Your signature must match the name you entered in Part A of the form.

### **Part E: Designated Legal Representative/Guardian – Complete this section only if you have documentation supporting legal representation.**

1. If you are signing this form on behalf of the Covered Individual (who is not your child) or you have Power of Attorney, be sure to print or type your first and last name, legal relationship to the Covered Individual, your address, and provide your signature and the date.
2. Be sure to submit the legal documentation requested in this section along with the completed form.

### **Part F: Submission**

1. To submit the completed form and supporting documents through the Secure Enrollee Portal (SEP) Message Center, you need to have an account on the SEP. If you do not have an SEP account, you can create one by visiting [www.healthtrustnh.org](http://www.healthtrustnh.org), scrolling to the orange Secure Login box on the home page, selecting “Covered Individual” and entering your information as requested.
2. If you do have an SEP account, log in to your account, select Message Center and click “New Message to HealthTrust.” Click the down arrow in the “Select a Destination” field and select Enrollee Services. Fill in the Subject, type your message in the Message field, and attach the form and any supporting documents where indicated. Click Send Message.
3. To submit the completed form and any supporting documents by mail or email, use the addresses included on the form.

For questions or assistance completing the form, please contact HealthTrust Enrollee Services at **800.527.5001** or via email at [enrolleeservices@healthtrustnh.org](mailto:enrolleeservices@healthtrustnh.org).