Experience Health

Member's Protected Health Information (PHI) Request Form

You may give Experience Health written authorization to disclose your protected health information (PHI) to anyone that you designate and for any purpose. If you want to authorize a person or entity to receive your PHI upon their request, please provide the information below. Completion of this form is not a condition or requirement of coverage and will not change the way that Experience Health communicates with you. For example, we will continue to send explanation of benefits (EOB) statements to you upon request. However, if your adult child calls Experience Health to inquire about you, your protected health information will not be shared with your adult child unless you have given Experience Health permission to do so by completion of this form.

Member Name (print): ______________________________

Member Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

Experience Health ID Number: ______________________

At my request, I authorize Experience Health to disclose my Protected Health Information (PHI) to: (If you choose, you may designate more than one person.)	
Name:	Phone:
Address:	Relationship to member:
Name:	Phone:
Address:	Relationship to member:

We request that you provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your PHI: A) your ID number, B) your date of birth, and C) your address.

I authorize Experience Health to disclose only the following Protected Health Information to the person designated above (check all that apply):

- ☐ Any information requested
- ☐ Premium Payment Information
- ☐ All claims information
- ☐ Enrollment information
- ☐ Benefit information
- ☐ Explanation of Benefits information
- ☐ All services from a specific health care provider (list provider's name): ______________
- ☐ Other (list specific PHI): ______________

Experience Health Medicare Advantage ^{SM} (HMO) Members: To authorize disclosure of your PHI about mental health/substance abuse services, please call the Mental Health/SA telephone number on the back of your ID card to request a separate authorization form.

I want the designated person to have access to my PHI until my policy expires OR until the specified date of: ☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

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Member's Protected Health Information (PHI) Request Form (continued)

I understand that I may revoke this authorization at any time by giving Experience Health written notice mailed to the address provided. However, if I revoke this authorization, I also understand that the revocation will not affect any action Experience Health took while this authorization was valid before Experience Health received my written notice of revocation.

I also understand that I do not have to authorize anyone to receive my PHI as a condition or requirement for coverage by Experience Health.

I also understand that if the persons or entities I have authorized to receive my PHI are not health plans, covered health care providers, or health care clearing houses subject to the Health Insurance Portability and Accountability Act (HIPAA), or other federal health information privacy laws, they may further disclose my PHI and it may no longer be protected by HIPAA or federal health information privacy laws.

Signature (Member or Personal Representative): ______________________

Date: __ __ / __ __ / __ __ __ __
(mm/dd/yyyy)

Personal Representative Name (print): ______________________

If signed by an Personal Representative, describe your authority to act for the member (e.g., durable power of attorney, court order, parent of minor child, etc.):

____

AND: Attach the legal document naming you as the Personal Representative when returning this form.

NOTE: We will consider the effective date of this authorization to be the date we enter this authorization into our computer system, typically 5 days following receipt. If you would like this authorization to become effective on a date after Experience Health enters the authorization into its system, please provide the date here:

__ __ / __ __ / __ __ __ __
(mm/dd/yyyy)

RETURN THIS AUTHORIZATION TO:

Attention: Data Operations
Experience Health
PO Box 2291
Durham, NC 27702

Experience Health is an HMO plan with a Medicare contract. Enrollment in Experience Health depends on contract renewal. ®, SM Mark of the Blue Cross and Blue Shield Association. Experience Health is an independent licensee of the Blue Cross and Blue Shield Association, serving North Carolina.