TRIPLE-S ADVANTAGE

TRIPLE-S SALUD
BlueCross BlueShield of Puerto Rico

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Purpose: Triple-S Advantage, Inc. and Triple-S Salud, Inc. are Covered Entities required by law to maintain the confidentiality, privacy and security of your health information. This form allows you to authorize one of the following entities to provide access to an individual or entity to your protected health information.

☐ Triple-S Advantage, Inc. ☐ Triple-S Salud, Inc.

Section A: Individual authorizing use and/or disclosure of information

Name: _____

Address:_____

Telephone: (___)_____ Cellular:(___)_____

Contract number: _____ Email: _____

To the Member or legal representative (Please Read)

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan or eligibility for benefits on receiving this authorization.

Effect of Granting this Authorization: The protected health information described below may be disclosed or received by individuals or entities that are not subject to Health information privacy laws, and it may no longer be protected by federal health information privacy laws.

Section B: Type of Information:

Protected Health Information, including, but not limited to information related to treatment, identification of treating care providers, diagnosis, procedures, demographic information, claims for coverage or benefits for all medical conditions (but not including psychotherapy notes). Including information in any mean, for example: oral, in paper or electronically.

Section C: Purpose of the Authorization

I understand that the covered entity selected above, does not disclose my personal health information to other parties, except those directly involved in my care, without my express consent, as established in the covered entity Notice of Privacy Practices. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named below for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits. I also understand that if my Authorized Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and my personal representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

☐ Member/Individual Request ☐ Legal Process ☐ Complaint ☐ Other _____

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION P. 2

Persons/Entities Authorized to receive information: List the names and demographic information of the persons or entities authorized to receive protected health information.

1. Name: _____

Address: _____

Driver's License: _____ Email: _____

Date of Birth: _____

Telephone: _____ Cellular: _____

Authorization Effective Date: _____

Authorization Expiration Date: _____

Relationship with the plan member/individual:

☐ Family Member ☐ Court appointed guardian ☐ Care Institution

☐ Lawyer ☐ Accountant ☐ Other:_____

Limitations on Disclosure:

I understand that I have the right to limit information that you release under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health care provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating no limitations to disclosure.

Describe limitations: _____

2. Name: _____

Address: _____

Driver's License: _____ Email: _____

Date of Birth: _____

Telephone: _____ Cellular: _____

Authorization Effective Date: _____

Authorization Expiration Date: _____

Relationship with the plan member/individual:

☐ Family Member ☐ Court appointed guardian ☐ Care Institution

☐ Lawyer ☐ Accountant ☐ Other:_____

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION P. 3

Limitations on Disclosure:

I understand that I have the right to limit information that you release under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health care provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating no limitations to disclosure.

Describe limitations: _____

Sections D: Expiration and Revocation

Expiration: This authorization to release information to your Authorized Representative will automatically expire in 24 months or before if you provided a shorter period on the expiration date section.

Right to Revoke: You may revoke this authorization at any time, submitting a written notification of revocation to the Compliance Department. The revocation of the authorization will have a prospective effect and will not affect the actions that the selected covered entity has taken according to the authorization that was in force before the revocation. Notification of revocation must include an effective date, your signature, and the date it was signed in order to be processed. Please submit your notification of revocation by email, fax, or mail, to:

Contact Office: Privacy Officer
Compliance Department

Address: PO Box 11320
San Juan, PR 00922-9905

Fax (787) 993-3260

Email: hipaacompliance@sssadvantage.com

Authorization:

I, _____, have had full opportunity to read and consider the contents of this Protected Health Information Disclosure Form. I confirm that this authorization is consistent with my request to the entity selected above. I understand that, by signing this form, I am confirming my authorization for the entity selected above to use/disclose my protected health information to the person(s) or entity designated above for the purpose described in this form.

Signature: _____ **Date:** _____

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION P. 4

IMPORTANT INFORMATION (Please Read):

If this authorization is signed by an authorized representative on behalf of the member/individual, please complete the information below and include **evidence of authority** *(Example: Power of Attorney, Designation of Guardian by Court with jurisdiction, Certification of the member's assigned primary Physician, indicating that you are in charge of the member's health care)*, **Note:** The document of representation in the Social Security or sworn statement is **Not** admissible for the purposes of this form as an authorized representative.

Personal Representative's Name: _____

Relationship to member/individual: _____

Evidence Included: _____

GENERAL REQUIREMENTS TO COMPLETE THE AUTHORIZATION FOR DISCLOUSURE OF PROTECTED HEALTH INFORMATION FORM.

- Must complete the entire form. The signature and authorization date are required for the document to be valid.
- The effective date of the authorization must be from or after the date of signature of the document.
- If evidence of an authorized representative is not included, the document will not be considered complete.
- If the Authorization Form is not completed correctly, it becomes invalid. This situation may cause a delay in our good services.