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 providers of care, diagnosis, procedures, demographic information, claims for coverage or benefits for any and all medical conditions (but not including psychotherapy notes).

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 written authorization. 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_____

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: _____

   Date of Birth: _____

   Email: _____

   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: _____

Date of Birth: _____

Email: _____

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: _____

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

TRIPLE-S ADVANTAGE TRIPLE-S SALUD
BlueCross BlueShield of Puerto Rico

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:** _____

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 Disclosure of Protected Health Information Form

- The signature and authorization date are required for the document to be valid
- 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

Triple-S Advantage, Inc. and Triple-S Salud, Inc. are firm in compliance with state and federal regulations regarding the privacy of protected health information of our members/individuals.

Triple-S Salud, Inc. cumple con las leyes federales aplicables de derechos civiles y no discrimina en base a raza, color, origen de nacionalidad, edad, discapacidad, o sexo.

Triple-S Salud, Inc. complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 787-774-6060, (TTY/TDD), 787-792-1370 or 1-866-215-1919. Free of charge 1-800-981-3241.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística llame al 787-774-6060, Libre de costo 1-800-981-3241. (TTY/TDD) al 787-792-1370 o 1-866-215-1919.

Triple-S Advantage, Inc. es una organización de cuidado coordinado (HMO, por sus siglas en inglés) y de proveedores preferidos (PPO, por sus siglas en inglés), con un contrato con Medicare, y con el Plan de Salud del Gobierno de Puerto Rico (Vital). La afiliación a Triple-S Advantage, Inc. depende de la renovación de contrato. Triple-S Advantage, Inc. es un concesionario independiente de la BlueCross and BlueShield Association.

Triple-S Advantage Inc. cumple con las leyes federales aplicables de derechos civiles y no discrimina en base a raza, color, origen de nacionalidad, edad, discapacidad, o sexo.

Triple-S Advantage Inc. 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Triple-S Advantage Inc. complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.

ATENCIÓN: si usted habla español, servicios de asistencia lingüística están disponibles libre de cargo para usted. Llame al: 1-888-620-1919 (TTY: 1-866-620-2520).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-620-1919 (TTY: 1-866-620-2520) 。

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-620-1919 (TTY: 1-866-620-2520).