OXFORD HEALTH PLANS®
A UnitedHealthcare Company

HIPAA MEMBER AUTHORIZATION

Except as otherwise permitted or required by applicable federal and state laws and regulations, Oxford Health Plans must obtain an authorization before using or disclosing protected health information ("PHI"). Upon receipt of a valid authorization for its use and/or disclosure of PHI, Oxford will make such use and/or disclosure in a manner consistent with such authorization.

To: Oxford Health Plans
Attn: Correspondence
P.O. Box 7081
Bridgeport, CT 06601-7081

Member Name: _____

Member I.D. Number: _____ Telephone: _____

Address: _____

Description of PHI: A description of the PHI to be used or disclosed:

_____

_____

Persons Authorized to Use or Disclose: The person(s), class of persons, or entity to whom Oxford is authorized to make the use or disclosure:

_____

_____

Description of each Purpose to Use or Disclose: A description of each purpose of use or disclosure (the statement "at the request of the Member" is sufficient):

_____

_____

Does the person(s), class of persons, or entity named above that Oxford is authorized to make the use or disclosure to also have the authority to file an appeal and/or grievance on behalf of the Member?

(check one) ☐ Yes ☐ No

Expiration:

This authorization will expire:

☐ Remain in place until_____. (*Date*)

☐ On occurrence of the following event (which must relate to the Member or to the purpose of the use and/or disclosure being authorized):

_____

_____

Revocation:

I understand that I may revoke this authorization at any time by giving written notice of my revocation to the HIPAA Member Rights Unit at the address provided below. I understand that any revocation of this authorization will *not* affect any action Oxford took in reliance on this authorization before Oxford received my written notice of revocation. I also understand that any revocation of this authorization will not result in my disenrollment from Oxford or denial of my eligibility for benefits.

HIPAA Member Rights Unit
Oxford Health Plans
48 Monroe Turnpike
Trumbull, CT 06611

Note the following:

- As an Oxford Member, your decision to sign this Authorization is voluntary and said decision will not impact treatment, payment, enrollment or eligibility for benefits under your Oxford coverage plan.
- If you instruct Oxford to release all of your PHI, please be aware that such release may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information relating to alcohol or drug abuse, genetic testing, psychiatric care and behavioral or mental health services and treatment.
- The PHI disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal and state laws and regulations.

Signature:

I have read and understand the contents of this document and am hereby providing my agreement to the terms of this Authorization.

Signature *: _____

Print Name: _____

Date: _____

* If a personal representative of an Oxford Member signs this Authorization, please provide a description and any available documentation of the authority to act in this capacity.

_____
_____
_____