AdventHealth Advantage Plans

Health First Health Plans

Authorization to:
Disclose Protected Health Information

In order for Advent Health Advantage Plans to disclose your Protected Health Information to another person or entity, you must complete and sign this form and return it to us. You can send it back to us through secure message or by emailing it to ahap-help@plusoscar.com. You can also mail in the form as outlined below. You have the right to receive a copy of this form. You may send this to AdventHealth Advantage Plans, Attn: Concierge Department, P.O Box 60788, Phoenix, AZ 85082-0788.

Full name: _____ Date of birth: _____

Phone #: _____ Member ID#: _____

Full Address: _____

I authorize AdventHealth Advantage Plans to disclose the following protected health information:

☐ All Records ☐ Records pertaining to: _____

Purpose:

☐ At my request only ☐ Other: _____

Disclose information to:

Name: _____ Relationship: _____

Phone: _____ Address: _____

How long should this authorization be in effect?

☐ This authorization should expire on: _____

If no expiration is specified, this authorization will expire 1 year from the date this form is signed.

Redisclosure: I understand that once AdventHealth Advantage Plans discloses my information pursuant to this authorization, the information may no longer be protected by federal and state privacy standards and my health information may be re-disclosed.

Revocation: I have the right to revoke (cancel) this authorization at any time by sending a written notice to the AdventHealth Advantage Plans at the address listed at the top of this form. I understand the revocation will not be effective until received by AdventHealth Advantage Plans. I am aware that my revocation will have no effect on disclosures made prior to the receipt of my revocation request.

Refusal: If I refuse to sign this form, my treatment, payment, enrollment or eligibility for benefits will not be affected.

Signature required: I have read and understood the terms of this form.

Signature: _____ Date: _____

Note: This form must be signed by either the member or his/her/their representative. If you are not the member, please sign below and indicate your relationship by checking the appropriate box.

Representative Signature: _____ Date: _____

Relationship: ☐ Power of Attorney* ☐ Other*: _____

*Documentation must be provided supporting your legal authority to act on the member's behalf.