



This form is used to advise Vibra Health Plan of the person or persons you have chosen to have access to your personal health information.

Where to return your completed authorization forms:

After you complete and sign the authorization form, return it to the address below:

Vibra Health Plan
ATTN: Member Services
PO Box 60250 Harrisburg PA 17106-0250

Or fax: 844.774.5585

If you have any questions or need additional assistance, please feel free to call us at [844.388.8268](tel:844.388.8268). Language assistance is available at no charge. TTY users should call 711.

Information to Help You Fill Out the *Vibra Health Plan Authorization to Disclose Personal Health Information* Form

By law, Vibra Health Plan must have your written permission (an “authorization”) to use or give access to your personal medical information for any purpose that isn’t set out in our privacy practices notice. You may take back (revoke) your written permission at any time, except if Vibra Health Plan has already acted based on your permission.

If you want Vibra Health Plan to give your personal health information to someone other than you, you need to let Vibra Health Plan know in writing.

If you are requesting personal health information for a deceased member, please include a copy of the legal documentation which indicates your authority to make a request for information. (For example: executor/executrix papers, next-of-kin attested by court documents with a court stamp and a judge’s signature, a letter of testamentary or administration with a court stamp and judge’s signature, or personal representative papers with a court stamp and judge’s signature). Also, please explain your relationship to the member.

Please use this step-by-step instruction sheet when completing your *Vibra Health Plan Authorization to Disclose Personal Health Information* form. Be sure to complete all sections of the form to ensure timely processing.

- 1.** Print the name of the person enrolled with Vibra Health Plan. Print the Vibra Health Plan member ID as is it is shown on the Vibra Health Plan ID card. Print the birthday in month, day and year (mm/dd/yyyy) of the Vibra Health Plan member.
- 2.** This section tells Vibra Health Plan what personal health information to give out. Please check a circle in 2a to indicate how much information Vibra Health Plan can disclose. If you only want Vibra Health Plan to give out limited information (for example, benefit information), also check the circle(s) in 2B that apply to the type of information you want Vibra Health Plan to give out.
- 3.** This section tells Vibra Health Plan when to start and/or when to stop giving out your personal health information. Check the circle that applies and fill in the dates, if necessary.

4. Vibra Health Plan will give your personal health information to the person(s) or organization(s) you fill in here. You may fill in more than one person or organization. If you designate an organization, you must also identify one or more individuals in that organization to whom Vibra Health Plan may disclose your personal health information.
5. The member of Vibra Health Plan or personal representative must sign their name, fill in the date, and provide the phone number and address of the Vibra Health Plan member. If you are a personal representative of the Vibra Health Plan member, check the circle, provide your address and phone number and attach a copy of the paperwork that shows you can act for that person (for example, Power of Attorney).
6. Send your completed, signed authorization to Vibra Health Plan at the address shown here or your authorization form.
7. If you change your mind and don't want Vibra Health Plan to give out your personal health information, write to the address shown under number six on the authorization form and tell Vibra Health Plan. Your letter will revoke your authorization and Vibra Health Plan will no longer give out your personal health information (except for the personal health information Vibra Health Plan has already given out based on your permission).

You should make a copy of your signed authorization for your records before mailing it to Vibra Health Plan.

Vibra Health Plan Authorization To Disclose Personal Health Information

Use this form if you want Vibra Health Plan to give your personal health information to someone other than you. **Please note:** this does not replace the Appointment of Representative form to file an appeal or grievance.

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|--|----------------------|-------------------------------|
| | | |
| 1. Print name
(First and last name of member) | Vibra Health Plan ID | Date of birth
(mm/dd/yyyy) |

Address

2. Vibra Health Plan will only disclose the personal health information you want disclosed.
- a. Check only one circle below to tell Vibra Health Plan the specific personal health information you want disclosed:
- Limited information (go to question b)
 - Any information (go to question 3)
- b. Complete only if you selected *limited information*. Check all that apply:
- Information about your eligibility
 - Information about your claims
 - Information about your plan enrollment
 - Information about your premium payments
 - Other specific information (please write below; for example, *payment information*)

3. Check only one circle below indicating how long Vibra Health Plan can use this authorization to disclose your personal health information.

- Disclose my personal health information indefinitely
- Disclose my personal health information for a specified period only:

Beginning (mm/dd/yyyy) _____

Ending (mm/dd/yyyy) _____

4. Fill in the name and address of the person(s) or organization(s) to whom you want Vibra Health Plan to disclose your personal health information.

Please provide the specific name of the person(s) for any organization you list below:

a. Name: _____

Address: _____

b. Name: _____

Address: _____

c. Name: _____

Address: _____

5. I authorize Vibra Health Plan to disclose my personal health information listed above to the person(s) or organization(s) I have named on this form. I understand that my personal health information may be redisclosed by the person(s) or organization(s) and may no longer be protected by law.

Signature

Telephone number

Date

Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (for example, Power of Attorney). This only applies if someone other than the Vibra Health Plan member signed above.

Print the personal representative's address:

Telephone number of personal representative: _____

Personal representative's relationship to member: _____

6. Send the completed, signed authorization to:

Vibra Health Plan
Attn: Member Services
PO Box 60250
Harrisburg, PA 17106

7. **Note:** You have the right to revoke (“take back”) your authorization at any time, in writing, except to the extent that Vibra Health Plan has already acted based on your permission. If you would like to revoke your authorization, send a written request to the address shown above. Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Vibra Health Plan pays for the health services you receive.

