700 Main Street, Suite 100
Alamosa, CO 81101
719-589-3696
Fax: 719-589-4901

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize Friday Health Plans to disclose my individually identifiable health information as described below.

Member Name: | **ID #:** | **Date of Birth:**

NAME, ADDRESS, & PHONE NUMBER of person(s) or organization(s) requesting records, if different than member.

NAME, ADDRESS, & PHONE NUMBER of person(s) or organization(s) to receive the records:

Please check one:

☐ I will review the records at Friday Health Plans

☐ I wish to have the records copied, and I will pick them up at Friday Health Plans.

☐ I am requesting that Friday Health Plans copy the records, and send them to the above address(es). ☐ I give permission for telephonic inquiry of claims or referral/authorization status to the above-named individual.

INFORMATION REQUESTED *(please initial)*

I am requesting the following records from my member record(s) that were created between the dates of
/ / and / /

(For all providers)

___ Claims History for Provider: Name _____

___ Referral/Authorization History for Provider: Name _____

___ Enrollment History

_____ Premium Payment History

Other: _____

Purpose for which records will be used: _____

LEGAL AUTHORITY REQUEST *(please initial)*

_____ I am the member noted above.

_____ I am the member's attorney-in-fact and have attached to this authorization a valid power of attorney that grants me the power to request the member's records.

_____ I am the member's legal guardian, and I have attached to this authorization a valid appointment of guardianship from a probate court.

_____ If the member is deceased: I am the executor/administrator of the member's estate, and I have attached to this authorization a valid appointment as such from a probate court, OR, if the estate did not go to probate court, I have attached a copy of the death certificate, and my relationship to the deceased is

_____

_____ The member has executed a legally binding instrument granting me the authority to obtain his/her records, and I have attached a copy of that instrument to this authorization.

Understandings and Agreements of Requestor

1. This authorization is voluntary. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my eligibility for benefits
2. This authorization will expire 90 days from the date of my signature below.
3. I understand that I may revoke this authorization at any time by notifying Friday Health Plans in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.
4. I agree to waive all claims against Friday Health Plans for the release of the requested information.
5. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by Friday Health Plans if the recipient of the information is not a health plan, health care provider, health care clearinghouse, or a business associate that has a contract with Friday Health Plans.
6. I understand that if I request that records be copied and sent to me that Friday Health Plans will make a good faith effort to send those records to me within thirty (30) days.
7. I understand that I must provide Friday Health Plans with at least three (3) weeks notice before coming to Friday Health Plans to review records. I understand that after I have reviewed the records, I must provide Friday Health Plans with thirty (30) days notice of any copies of the records that I would like to pick up at Friday Health Plans.
8. I understand that if I wish to have copies of records made, then Friday Health Plans will assess a fee for copying the records, which has been set by Colorado law as follows: $10 for ten or fewer pages; $0.50 per page for pages 11-40, and $0.33 per page after 40 pages.
9. Friday Health Plans will notify me of the total amount due for copying and shipping of the requested records; I agree that Friday Health Plans will send me the requested information once it has received payment in full for those costs.

Printed Name of Requestor: _____

Signature of Requestor: _____

Date of Request: _____

Completed form should be returned to:

Friday Health Plans
700 Main, Suite 100
Alamosa, CO 81101
Fax: 719-589-4901
Ph: 719-589-3696

For Internal Use Only

Received by: _____

Date: _____

Respondent Name: _____

Date: _____

Cost of Copying: $_____

Date Member Notified: _____

Date Payment Received: _____

Completion Date: