Health First
Health Plans

6450 US Highway 1
Rockledge, Florida 32955
myHFHP.org

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

According to state and federal law, Health First Health Plans must have your written permission to use or give out your PHI for any purpose that is not described in our Notice of Privacy Practices.* If you want your PHI shared with someone other than you, you need to let Health First Health Plans know by completing this form. ***This form authorizes Health First Health Plans to disclose your PHI to the person indicated below.***

INSTRUCTIONS: Complete all pages of this form. Please print all responses. This form must be filled out completely in order to be valid. Once completed please deliver, mail or fax the form to:

Health First Health Plans

6450 U.S. Highway 1
Rockledge, FL 32955
Attn: Enrollment Department

Fax: 855.328.0055

A. MEMBER INFORMATION

Member Name: _____
Last First Middle

Member ID Number: _____ Date of Birth: _____

B. AUTHORIZED INDIVIDUAL(S) SECTION

Name of person to whom you are authorizing Health First Health Plans to disclose your PHI.

1) Name:

_____
Last First Middle

Address: _____

Telephone: _____

2) Name:

_____
Last First Middle

Address: _____

Telephone: _____

C. PURPOSE OF THE DISCLOSURE

By signing this form, I authorize Health First Health Plans to disclose my PHI to the authorized individuals listed above for the following purposes (check all that apply):

- ❑ Accessing my enrollment information (such as name, address, employer, effective date, etc.)
- ❑ Accessing my financial information
- ❑ Accessing my claims and authorizations (which may include diagnosis, procedures performed, providers seen, and case management records)
- ❑ All of the above

D. TERM

This Authorization will remain in effect indefinitely, or until the date indicated below:

❑ _____(specify date)

Uses and disclosures of protected health information not covered by the Notice of Privacy Practices* or other applicable laws will be made only with your written permission. If you provide us permission to use and disclose your protected health information, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose your protected health information for the reasons covered by your written permission. We are unable to take back any disclosures we have already made with your permission, and must retain our records of services provided to you. If we disclose information to your authorized individual, we cannot guarantee that your authorized individual will not further disclose the protected health information to a third party, and that state and federal laws may no longer protect such information. Completion of this form does not affect the continuation or quality of treatment by Health First, enrollment in the health plan or eligibility for benefits.

I have read and understand the terms of this Authorization. I hereby, knowingly and voluntarily, authorize Health First Health Plans to use or disclose my health information in the manner described above.

_____ _____

Signature of Member Date

If signed by a Legal Representative on behalf of the member, please complete the following:

a) Print your full name:_____

b) Describe your legal authority to act for the member (e.g., durable power of attorney, court order, parent of minor child, etc.)

_____

c) Attach the legal document naming you as the legal representative when you return this form.

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Signature of Legal Representative

Date

*The Notice of Privacy Practices can be found on the Health First Health Plans website at myHFHP.org or you can call Customer Service toll-free at 1.855.443.4735 (TTY/TDD relay:1.800.955.8771) weekdays from 8 a.m. to 6 p.m.

Health First Commercial Plans, Inc. and Health First Insurance, Inc., are both doing business under the name of Health First Health Plans. Health First Health Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

36194-77150_MPINFO425 (02/2018)

Nondiscrimination Notice

Health First Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health First Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health First Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services, please contact Civil Rights Coordinator.

If you believe that Health First Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, 6450 US Highway 1, Rockledge, FL 32955, 321-434-4521, 1-800-955-8771 (TTY), Fax: 321-434-4362, civilrightscoordinator@health-first.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

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36194-77150_MPINFO324 (08/2017)

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English:

If you, or someone you're helping, has questions about Health First Health Plans, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-443-4735.

Spanish:

En caso que usted, o alguien a quien usted ayude, tenga cualquier duda o pregunta acerca de Health First Health Plans, usted tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-443-4735.

Haitian Creole:

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Health First Health Plans, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 855-443-4735.

Vietnamese:

Nếu Quý vị, hay người mà Quý vị đang giúp đỡ, có câu hỏi về Health First Health Plans thì Quý vị có quyền được trợ giúp và được biết thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, xin gọi số 855-443-4735.

Portuguese:

Você ou alguém que você estiver ajudando tem o direito de tirar dúvidas e obter informações sobre os Health First Health Plans no seu idioma e sem custos. Para falar com um tradutor, ligue para 855-4434735.

Chinese:

如果您，或是您正在協助的對象，有與 Health First Health Plans 相關的問題，您有權以您的母語免費取得幫助和資訊。請致電 855-443-4735 與翻譯員洽談。

French:

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Health First Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-443-4735.

Tagalog:

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Health First Health Plans, may karapatan ka na humingi ng tulong at impormasyon sa iyong wika nang libre. Upang makausap ang isang tagasalin, tumawag sa 855-443-4735.

Russian:

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Health First Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 855-443-4735.

Arabic:

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Health First Health Plans، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بالرقم 855-443-4735.

Italian:

Se lei o qualcuno che sta aiutando avete domande su Health First Health Plans, ha il diritto di ottenere aiuto e informazioni nella sua lingua gratuitamente. Per parlare con un interprete, può chiamare il numero 855-443-4735.

German:

Falls Sie oder jemand, dem Sie helfen, Fragen zum Health First Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-443-4735 an.

Korean:

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Health First Health Plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 855-443-4735 로 전화하십시오.

Polish:

Jeśli Ty lub osoba, której pomagasz, macie pytania na temat Health First Health Plans, macie Państwo prawo do bezpłatnego uzyskania informacji i pomocy w języku ojczystym. Aby porozmawiać z tłumaczem, prosimy zadzwonić pod numer 855-443-4735.

Gujarati:

જો તમે અથવા તમે કોઇને મદદ કરી ર ા હો તેમાથંી કોઇને ઇ થ ફ ટર્ ઇ થ લા સ િવશે પ્ર ો હોય તો તમને તમારી ભાષામાં િવના મયૂે મદદ અને મા િહતી મેળવવાનો અિધકાર છે. દુભા ષિયા સાથે વાત કરવા માટે 855-443-4735 પર કૉલ કરો.

Thai: หากคณุ หรือคนที่คณุ กำลงั ช่วยเหลือมีคำถามเกี่ยวกบั Health First Health Plans คณุ มีสทิธิที่จะได้รับความช่วยเหลือและข้อมลู ในภาษาของคณได้โดยไมม่ ีคา่ ใช้จ่าย หากต้องการพดู คยกบั ลุ าม่ โปรดโทร 855-443-4735.

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