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Authorization to Use or Disclose Protected Health Information

In order for Oscar to speak to someone other than you about your health information (including claims data, dates of service, providers that provided care to you, etc.), you must complete the following authorization form and return it to us. The following form complies with the Health Insurance Portability and Accountability Act ("HIPAA"). Once you complete it, please mail it to **Oscar's Privacy Officer at 295 Lafayette Street, 6th Floor, NY, NY 10012**.

Please complete the form carefully and completely, otherwise the form will not be considered valid.

1. Your Member Information

Member Name: _____ Date of Birth _____

Member #: _____

Home Address: _____

Home Phone Number: _____

2. Who do you want to provide access to your information?

Name of person I wish to authorize (the Recipient):_____

Address: _____

Telephone Number: _____

Relationship to me (i.e. mother): _____

3. What is the purpose of this authorization?

☐ No specific reason ☐ I need help with an appeal ☐ I need help with a claims payment

☐ I feel more comfortable with a family member / friend helping me

Other reason (please type below):

_____

4. What information do you want this person to have access to?

☐ All information including claims, billing information, clinical, etc.

OR….

☐ Only the following specific information (please list below – you may include a specific date range and/or a doctor's name if you only want the Recipient to get information about services you received from that provider):

_____

IMPORTANT NOTE:

Certain sensitive information may only be released if you specifically indicate to us that we should provide it to your Recipient. Please check below all categories that you would like us to disclose information about**:

☐ Alcohol/substance abuse ☐ Genetic markers ☐ HIV/AIDS

☐ Sexually transmitted diseases ☐ Mental health (excluding psychotherapy notes)

***(any item that you do not check will NOT be disclosed to your Recipient, even if you checked "all information" in Question # 4 above or it falls within a date range provided).*

5. How long do you want this authorization to last?

This authorization should expire on _____(insert date), **OR**……

When the following event happens: _____

(If you do not provide a date, this authorization will expire 24 months from the date that you sign this form).

Conditions of Authorization: You understand that the information you disclose following this authorization may be further disclosed by the Recipient. You have the right to revoke (cancel) this authorization by sending a written notice to Oscar's Privacy Officer at the address listed on the top of this form. Cancellation is effective upon receipt by Oscar's Privacy Officer. Revocation/cancellation will not affect any action taken by Oscar in reliance on this authorization prior to receiving your written notice of cancellation. You may refuse to sign this form; your benefits, coverage and any payments will not be affected.

Signature required: You have read and understood the terms of this authorization. You have had a chance to ask questions about how your health information will be used and disclosed. By signing this authorization, you affirm that to the best of your knowledge, all information provided on this form is complete, accurate and consistent with your directions. You hereby provide your agreement to the terms authorizing the use and disclosure of your health information in the manner described in this form.

Signature of Member _____ Date _____

Note: This form must be signed by either the member or his/her personal representative (someone who has legal authority to act on the member's behalf).

If you are not the member, please sign below and indicate your relationship to the member. A parent MUST sign for a minor dependent child.

Signature of Member's Personal Representative: _____ Date _____

Representative's Relationship to the Member:

☐ Parent ☐ Legal Guardian* ☐ Power of Attorney* ☐ Other*

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