ALERAPAY
POWERED BY ALERAEDGE

AUTHORIZATION TO SHARE MY PROTECTED HEALTH INFORMATION

RETURN FORM TO: AleraEdgePay@AleraGroup.com **OR Fax:** 585-641-7500
OR Mail: 800 Parker Hill Drive, Suite 100, Rochester, NY 14623

Protecting your confidentiality is important to ALERA Pay. HIPAA laws protect how and when your health care and personal information can be shared. If you would like Alera Pay to share information about you with another party, please complete this form. This includes sharing information with a spouse, friend, or even a parent, if you are over the age of 18. Your submission of this completed and signed form gives Alera Pay permission to share your health information with the people you authorize (in SECTION 3). Your authorization is completely voluntary.

Important Notes: State and federal laws require special protections for HIV/AIDS, mental health, alcohol or substance abuse, pregnancy, abortion, family planning, sexually transmitted diseases, and genetic testing. If you would like Alera Pay to only share information on specific protected diagnoses, please clearly state this below in the options regarding specific information.

Alera Pay will only release information about a minor regarding abortion, sexually transmitted diseases, or substance abuse, if the minor completes and submits this authorization—even to disclose this information to a parent.

SECTION 1: PERSON WHOSE INFORMATION IS TO BE RELEASED

Name: ______________________ Date of Birth ______________

Address: ______________________ Relation to Employee ______________

City: ______________________ State: ______________ Zip Code: ______________

Employee/Plan Holder's Name: ______________________

Employee/Plan Holder's Employer: ______________________

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting revocation in writing to the entity providing the information.

SECTION 2: THE HEALTH INFORMATION TO BE RELEASED

All Health Information (allows another person to act on your behalf for questions or issues)

Membership Information (i.e. coverage information, enrollment dates, eligibility, address, dates of birth, etc.)

Benefit Information (i.e. benefits available, benefits used, contract limits, etc.)

Medical Records (i.e. physician or hospital records, case management, etc.)

Claim Information (i.e. coverage information, enrollment dates, eligibility, address, dates of birth, etc.)

Other (specify the information you are authorizing)

If Other, explain: ______________________

The following items must be specifically indicated in order to disclose this information with the person(s) appointed:

HIV/AIDS related information and/or records

Mental health information and/or records

Drug/alcohol diagnosis &/or treatment information

Pregnancy, abortion &/or family planning information

Sexually transmitted disease information

Genetic testing

SECTION 3: PERSON/s OR ORGANIZATION TO RECEIVE THIS INFORMATION

1—Name: ______________________________

Address: ______________________________

City: ____________________ State: __________ Zip Code: __________

Relationship: ______________________________

2—Name: ______________________________

Address: ______________________________

City: ____________________ State: __________ Zip Code: __________

Relationship: ______________________________

SECTION 4: UNDERSTANDING YOUR RIGHTS

The person(s)/organization noted above are authorized to receive my individually identifiable health information for the specific purpose of assisting with claims, membership and or benefit eligibility issues. This authorization shall be in force until Alera Pay no longer maintain the health information or until revoked by the undersigned in the manner described below OR until (insert applicable date)

______________________________ .

I may revoke this authorization at any time prior to its expiration date by notifying Alera Pay, but the revocation will not have any effect on any actions the authorized entity/entities took before it received the revocation. I may see and copy the information described on this form if I ask for it. I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment). The information that is used or disclosed pursuant to this authorization may be disclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not disclosed the information to any other party.

The revocation should clearly state your intent to revoke this authorization and the effective date of revocation.

SECTION 5: SIGN AND DATE THIS FORM

To give Alera Pay your permission to share your health information with the people/organization you have authorized, please sign, date and print on the lines below.

I, (please print name here) ______________________________
have read and understand the contents of this authorization.

I understand my signature on this form authorizes the use, request, and release of my individually identifiable health information as described in this form.

I understand that I may cancel this authorization at any time with proper written notice as outlined above.

I understand that if the person(s) or organization I authorize to receive information is not subject to federal health information privacy laws, he/she may further disclose the information and may no longer be protected by those laws.

Signature: ______________________________ **Date:** ______________

Personal Representative's Name *(please print)*: ______________________________

Description of Authority
(power of attorney, legal guardian, etc.): ______________________________