AUTHORIZATION TO RELEASE INFORMATION FORM

Authorization to Disclose Information (ADHI) (Medical Coverage)

CHAND
Comprehensive Health Association of North Dakota

You are entitled to a copy of this form after you sign it. Please notify us of any changes to the information provided on this form. If you have questions, please call the number on the back of your member ID card.

Return completed forms by:

- Fax: (701) 282-1888
- Mail: CHAND Service Center
  4510 13th Ave S
  Fargo, ND 58121

Section A: Purpose of Form

This form is used to request and authorize CHAND to use and disclose my health information with another person or entity.

Section B: Member Information

Please type or print clearly. This individual should sign Section F.

Member ID															Daytime Phone Number		
Last Name						First Name									MI	Suffix	Birth Date (*mm/dd/yyyy*)
Address																	
City															State		Zip Code

Section C: Authorized Use and/or Disclosure

By signing this form, I am allowing CHAND to use and disclose my health information as outlined in Section D with the following individual(s) and/or organization(s) listed below.

I understand that if the individual(s) and/or organization(s) is not subject to federal or applicable state privacy laws, my health information may no longer be protected by those privacy laws, and the individual(s) and/or organization(s) may further use and disclose my health information without my authorization. I acknowledge that my authorization is voluntary.

Individual or Entity Name															Phone Number		
Address																	
City															State		Zip Code

Lead carrier services provided by Blue Cross Blue Shield of North Dakota

PLEASE COMPLETE BOTH SIDES OF THIS FORM.
If you have questions, please call the number on the back of your member ID card.

4510 13th Avenue South, Fargo, North Dakota 58121

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Section D: Type of Information

I allow the following information to be used or disclosed by CHAND on my behalf **(CHECK ONLY ONE BOX)**:

☐ **Psychotherapy Notes**: Federal law requires a separate authorization to use or release psychotherapy notes. If you check this box, you may not check another box below.

OR

☐ **All My Information**: Includes health diagnosis, claims, doctors, premium billing and payment information, including maternity, sexually transmitted disease, AIDS, HIV, alcohol, drug or other substance abuse, behavioral and mental health and other sensitive medical information that applicable law may protect.

OR

☐ **Only Limited Information** (check all that apply):

- ☐ Appeal information
- ☐ Benefits and coverage
- ☐ Premium billing and payment
- ☐ Claims and payment
- ☐ Other: _____
- ☐ Eligibility and enrollment
- ☐ Pre-certification and pre-authorization
- ☐ Referral
- ☐ Pharmacy

NOTE: Certain Federal and State laws require that you give specific permission to use or release the information below, even if you checked a box above. Indicate your permission for the disclosure of the following information by checking all that apply:

- ☐ Alcohol/substance abuse*
- ☐ Other: _____

* I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulation and cannot be used or disclosed without my written consent unless otherwise provided for in the laws and regulations.

Section E: Expiration and Revocation

This authorization will be valid for this one-time release of information unless otherwise specified below. Any date specified cannot exceed 12 months from the date of the covered member's signature below.

☐ Valid for one year from the signature date in Section F.

☐ Earlier than one year and upon the date or event described below:

_____

I may revoke this authorization at any time by giving written notice of revocation to CHAND Member Services at the address listed on the back of my member ID card. I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released, based upon this authorization before you actually receive my request to revoke it.

Section F: Signature/Authorization

I understand this authorization is voluntary. I understand my treatment, payment, and enrollment in a health plan or eligibility for benefits is not conditioned on receiving this authorization.

I have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

Print Name	
Signature	Today's Date (*mm/dd/yyyy*)

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