健康資訊使用與披露授權書

Notice to Member:

- Completing this form will allow Superior HealthPlan to (i) use your health information for a particular purpose, and/or (ii) share your health information with the individual or entity that you identify on this form.
- You do not have to give permission to use or share your health information. Your services and benefits with Superior will not change if you do not submit this form.
- If you want to cancel this authorization form, send us a written request to revoke it at the address on the bottom of this page. A revocation form can be provided to you by calling Superior.
- Superior cannot promise that the person or group you allow us to share your health information with will not share it with someone else.
- Keep a copy of all completed forms that you send to us. We can send you copies if you need them.
- If you need help or if you have questions about this form, please call Superior.
- Fill in all the information on this form. When finished, mail or fax the form and any supporting documentation to:

  Superior HealthPlan, ATTN: Compliance Department
  5900 E. Ben White Blvd., Austin, TX 78741

  Fax: 1-833-205-1935

  If you prefer to submit the form online, you can submit using the electronic form on our website. Please visit: SuperiorHealthPlan.com/AuthToDisclose.

保戶須知：

- 填寫本授權書將允許Superior HealthPlan (i) 將您的健康資訊用於特定目的，和/或 (ii) 與您在本授權書上所確認的個人或實體分享您的健康資訊。
- 您無需授予許可即可使用或分享您的健康資訊。若您未提交本授權書，您在Superior的服務與福利並不會變更。
- 如果您想要取消本授權書，請透過本頁面底部的地址將書面撤銷申請寄送給我們。可致電Superior，我們向您提供撤銷表格。
- 對於您允許我們分享您健康資訊的人士或團體，Superior無法保證他們將不會與他人分享您的健康資訊。
- 請保留您寄送給我們的所有填妥表格的副本。如有需要，我們可以將副本寄送給您。
- 如果您需要幫助或對此表格有任何疑問，請致電Superior。
- 請填寫本授權書上的所有資訊。完成後，請將本授權書和任何佐證文件郵寄或傳真至：

  Superior HealthPlan, ATTN: Compliance Department
  5900 E. Ben White Blvd., Austin, TX 78741

  Fax: 1-833-205-1935

  如果您希望線上提交表格，可以使用我們網站上的電子表格提交。請瀏覽：
  SuperiorHealthPlan.com/AuthToDisclose。

PLEASE READ THE INSTRUCTIONS CAREFULLY AND COMPLETE THE FORM BELOW. INCOMPLETE FORMS CANNOT BE ACCEPTED.

1 **MEMBER INFORMATION:**

Member Name *(print)*: ____

Member Date of Birth: ____________________ Member ID Number: ______________________________

2 **I GIVE SUPERIOR HEALTHPLAN PERMISSION TO USE MY HEALTH INFORMATION FOR THE PURPOSES IDENTIFIED OR TO SHARE MY HEALTH INFORMATION WITH THE PERSON OR GROUP NAMED BELOW. THE PURPOSE OF THE AUTHORIZATION IS EITHER:**

- to allow Superior to help me with my benefits and services; **OR**
- to permit Superior to use or share my health information.

3 **PERSON OR GROUP TO RECEIVE INFORMATION** *(add more persons or groups on next page)***:**

Name (person or group): ____

Address: ____

City: __________________ State: ______________ Zip: __________ Phone: (_______) _______ - _______

4 **I AUTHORIZE SUPERIOR TO USE OR SHARE THE FOLLOWING HEALTH INFORMATION** *(NOTE: Select the first statement to release ALL health information or select the below statement to release only SOME health information. **Both CANNOT be selected.**)*

□ **All of my health information INCLUDING:**

Genetic information, services or test results; HIV/AIDS data and records; mental health data and records (but not psychotherapy notes); prescription drug/medication data and records; and drug and alcohol data and records (please specify any substance use disorder information that may be disclosed);

OR

□ **All of my health information EXCEPT** *(check all boxes below that apply)***:**

- □ Genetic information, services or tests
- □ AIDS or HIV data and records
- □ Drug and alcohol data and records
- □ Mental health data and records (but not psychotherapy notes)
- □ Prescription drug/medication data and records
- □ Other: ____

5 **THIS AUTHORIZATION ENDS ON THIS DATE/EVENT:** ______________________________

Date this authorization ends unless cancelled. If this field is blank, the authorization expires one year from the date of the signature below.

- -

6 **MEMBER OR LEGAL REPRESENTATIVE SIGNATURE:** ______________________________

DATE: ______________________________

IF LEGAL REPRESENTATIVE - Relationship to Member: ______________________________

*If you are the Member's legal or personal representative, **you must send us copies of relevant forms**, such as power of attorney or order of guardianship.*

MAIL COMPLETED AUTHORIZATION FORM AND ANY SUPPORTING DOCUMENTATION TO

SUPERIOR HEALTHPLAN, ATTN: COMPLIANCE DEPARTMENT
5900 E. BEN WHITE BLVD., AUSTIN, TX 78741

ADDITIONAL INDIVIDUAL PERSON(S) OR GROUP(S) TO RECEIVE INFORMATION:

NOTE: If you are consenting to disclose any substance use disorder records to a recipient that is neither a third party payor nor a health care provider, facility, or program where you receive services from a treating provider, such as a health insurance exchange or a research institution (hereafter, “recipient entity”), you must specify the name of an individual with whom or the entity at which you receive services from a treating provider at that recipient entity, or simply state that your substance use disorder records may be disclosed to your current and future treating providers at that recipient entity.

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip: ______________ Phone: (   )   - ______

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip: ______________ Phone: (   )   - ______

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip: ______________ Phone: (   )   - ______

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip: ______________ Phone: (   )   - ______

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip: ______________ Phone: (   )   - ______

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip: ______________ Phone: (   )   - ______

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip: ______________ Phone: (   )   - ______

Name (individual or entity): ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip: ______________ Phone: (   )   - ______

請仔細閱讀說明並填寫下方表格。未填妥的表格將不予接受。

1 **保戶資訊：**

保戶姓名 *（正楷）*：______________________________

保戶出生日期：____________________ 保戶ID號碼：____________________

2 **本人授權SUPERIOR HEALTHPLAN，可基於已確認之目的使用我的健康資訊，或將我的健康資訊分享給下方所示之人士或團體。授權的目的為：**

- 允許Superior協助我處理福利與服務，**或**
- 允許Superior出於以下目的使用或分享我的健康資訊。

3 **接收資訊的人士或團體** *（請在下一頁新增更多人士或團體）*：

名稱（人士或團體）：______________________________

地址：______________________________

城市：______________ 州：__________ 郵遞區號：__________ 電話：(_____) _______ - __________

4 **本人授權SUPERIOR使用或分享下列健康資訊** *（註：請選擇第一個聲明以披露所有健康資訊，或選擇下方的聲明以僅披露部分健康資訊。**不得同時選擇兩個選項。**）*

☐ **我的所有健康資訊，包括：**

基因資訊、服務或檢測結果；HIV/AIDS 資料與記錄；精神健康資料與記錄（但不是心理治療記錄）；
處方藥/藥物資料與記錄；以及藥物和酒精資料與記錄（請說明任何可能披露的物質使用障礙資訊）；

或

☐ **我的所有健康資訊，但不包括** *（僅勾選下列適用的方塊）*：

☐ 基因資訊、服務或檢測
☐ AIDS 或 HIV 資料與記錄
☐ 藥物和酒精資料與記錄
☐ 精神健康資料與記錄（但不是心理治療記錄）
☐ 處方藥/藥物資料與記錄
☐ 其他：______________________________

5 **本次授權終止的日期/事件：**______________________________

請註明本次授權終止的日期，取消除外。如果不填寫此欄位，則授權將自下方簽名日期起一年後到期。

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6 **保戶或法定代表簽名：**______________________________

日期：____________________

若為法定代表，請填寫與保戶的關係：______________________________

*如果您是保戶的法定或個人代表，**您必須將相關表格的副本寄送給我們**，例如委託書或監護令。*

請將填妥的授權書和任何佐證文件郵寄至

SUPERIOR HEALTHPLAN, ATTN: COMPLIANCE DEPARTMENT

5900 E. BEN WHITE BLVD., AUSTIN, TX 78741

接收資訊的其他個人或團體：

註：如果您同意將任何物質使用障礙記錄披露給的接收方既不是第三方付款人，也不是您從治療提供者接受服務的醫療服務提供者、機構或計畫，例如健康保險交易所或研究機構（以下簡稱「接收方實體」），您必須指定您從該接收方實體的治療提供者接受服務的個人或實體的名稱，或者簡單地聲明您的物質使用障礙記錄可以披露給該接收方實體目前和未來向您提供服務的治療提供者。

名稱（個人或實體）：

地址：

城市： 州： 郵遞區號： 電話：( ) -

名稱（個人或實體）：

地址：

城市： 州： 郵遞區號： 電話：( ) -

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地址：

城市： 州： 郵遞區號： 電話：( ) -