Enrollee Authorized Designee

I hereby authorize Atlantis Health Plan, Inc. and their respective employees, agents and subcontractors to disclose my PHI and Insurance Record to the designee identified below.

1. Member Information

Member ID	Last Name	First Name	Date of Birth

Street Address	City	State	Zip

Daytime Telephone Number	Evening Telephone Number

2. Authorized designee to receive PHI/ Insurance Record pertaining to the Member Identified above:

Last Name	First Name	Daytime Telephone Number

Street Address	City	State	Zip

Relationship to Member

In accordance with New York State Law and Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE**, **MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 3. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 3, I specifically authorize release of such information to the person indicated in Item 2.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to Atlantis Health Plan. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in Atlantis Health Plan, or eligibility benefits will not be conditioned upon my authorization of disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted in #2 above), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY PERSONAL HEALTH INFORMATION AND INSURANCE RECORD WITH ANYONE OTHER THAN THE PERSON AUTHORIZED IN ITEM 2.

3. This authorization will apply to any and all request for PHI, as well as information pertaining to my insurance record which is not limited to my treatment, payment, enrollment in Atlantis Health Plan, and eligibility benefits.
Additional Information to be released (Indicate by Initialing):

_______ Alcohol and Drug Treatment   _______ Mental Health Information   _______ HIV-Related Information

This authorization will be in effect for one year from the date signed, unless you indicate a shorter period: __________ through __________

_______________________________________   **Date:** ______________________
Signature of Member

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

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