ASPIREHEALTHPLAN

COASTALTPA
A subsidiary of Aspire Health Plan

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

You can use this form to authorize Aspire Health Plan and its subsidiaries, including Coastal TPA (collectively, “Aspire Health Plan”), to use or disclose your protected health information. Please complete, sign and return this form via fax to 831-657-2669 or mail to:

Aspire Health Plan
10 Ragsdale Drive, Suite 101
Monterey, CA 93940

Member Information (Required)

Member First Name________________________ Member Last Name ________________________

Member ID___________________ DOB ____/____/______ Phone __________________________

I hereby authorize Aspire Health Plan to disclose the protected health information listed below to the following person(s)/entity:

Name			
Relationship to member		Address	
		City/State/Zip	

Name			
Relationship to member		Address	
		City/State/Zip	

Please specify what information you would like to be disclosed to the individual listed above:

- ☐ All personal healthcare information (includes all options below)
- ☐ Health Related Information
- ☐ Billing and Claims information
- ☐ Mental Health Related Information (except psychotherapy notes*)
- ☐ Provider/PCP Information
- ☐ Enrollment and Demographic Information or Changes

Sensitive Information: If Aspire Health Plan has any of the following types of information, you must check off the box next to the category before we can disclose the information:

☐ Information related to my diagnosis, treatment, and/or referral for substance use disorder, including information received through claims, care management and/or utilization review.

☐ Information related to my diagnosis and/or treatment for HIV/AIDS

☐ Results of genetic testing

☐ Sexually transmitted diseases

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Please describe the purpose for the disclosure (be specific, e.g., "To assist with claims payment" or you may write, "at my request"): ____

____

This authorization will remain in effect:

☐ For as long as necessary to complete the purposes of this Authorization.

☐ From the date of this Authorization until the following date: ____________________

☐ Until the following event occurs: ____

Please Note:

- You have a right to revoke this authorization in writing at any time and to send your written revocation to Aspire Health Plan at the address listed below. Your revocation will not apply to information that Aspire Health Plan has already disclosed in reliance on this Authorization.
- Information disclosed by Aspire Health Plan in accordance with this request may be disclosed by the recipient and may no longer be protected by the HIPAA Privacy Regulations.
- Aspire Health Plan will not condition payment, enrollment in the health plan, or eligibility for benefits on you providing this authorization.
- While this form allows for the release of PHI to the person or party indicated, it does not allow that person or party to access the member's PHI online through the member portal.
- You have the right to receive a copy of this authorization.

SIGNATURE OF **MEMBER** (BENEFICIARY)		TODAY'S DATE
STREET ADDRESS		
CITY	STATE	ZIP

I am signing this authorization voluntarily, and I understand that the Plan may not control my treatment, payment, enrollment, or eligibility for benefits on whether I agree to sign this Authorization. I understand that I have the right to revoke this authorization at any time by sending a letter to Aspire Health Plan.

If you have any questions, please call Aspire Health Plan at (831) 657-0700.

**Note: This form cannot be used for psychotherapy notes. If you seek to authorize the use or disclosure of psychotherapy notes, then you will need to do so using a separate form.*