DetegoHealth
Discover A Better Plan

Release of Protected Health Information Authorization Form

As required by the Health Insurance Portability and Accountability Act (HIPAA), Detego Health and its subsidiaries may not use or disclose your protected health information except as provided in our Notice of Privacy Practices. Your signature on this form indicates you are giving permission for Detego Health to provide your protected health information to the person or entity named below.

Member Information

First Name:		Last Name:	
Address:			
City:	State:	Zip Code:	
Phone Number:		Email Address:	
Member ID Number:			

Authorized Individuals

First and Last Name	Relationship to Member	Phone Number	Disclosure Option
			_____ Full Disclosure _____ Limited Disclosure
			_____ Full Disclosure _____ Limited Disclosure
			_____ Full Disclosure _____ Limited Disclosure
			_____ Full Disclosure _____ Limited Disclosure
			_____ Full Disclosure _____ Limited Disclosure
			_____ Full Disclosure _____ Limited Disclosure
			_____ Full Disclosure _____ Limited Disclosure

Information to be Disclosed

_____Full Disclosure: Any and all protected health information that Detego Health maintains, including but not limited to mental health, HIV, or substance abuse.
_____Limited Disclosure: Select below to specify what information Detego Health can share.
_____Personal Health / Diagnosis Information
_____Claim Payment Information
_____Coordination of Benefits
_____Prescription Drug Information
_____Specific Dates of Service. List all that apply: _____
_____Other: _____

Authorization

I authorize the use or disclosure of my protected health information by Detego Health to the following individual(s) or entity.
This authorization will expire _____. If no expiration date or event is indicated, this authorization will expire when my enrollment with Detego Health ends. I also understand I may revoke this authorization at any time by providing Detego Health with written notice of revocation at the address listed below. If I do revoke this authorization, it will not have any effect on any information released before revocation, including any action taken by the individual or entity that received the protected health information.
Protected health information used or disclosed as instructed by this authorization may be further disclosed by the individual or entity receiving the protected health information and, therefore, no longer protected by HIPAA.
I understand I am under no obligation to sign this authorization. I further understand my ability to obtain insurance or eligibility for benefits will not depend in any way on whether I sign this authorization.
A copy of this Authorization Form is available to me or to my Legal Representative upon request.

Member Signature

Print Name:		
Signature:		Date:

Completed forms can be submitted via mail, or fax.
Detego Health
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Omaha, NE 68154
Phone: 866-815-6001 ● Fax: 855-613-4102