UNIVERSITY of MARYLAND HEALTH PARTNERS

HIPAA Privacy Consent & Authorization Form

Consent and Notice of Privacy Practices

This consent form allows University of Maryland Health Partners to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This information may be used or disclosed to carry out treatment, payment, or health care operations.

University of Maryland Health Partners has provided me with a Notice of Privacy Practices, which completely describes uses and disclosures of my protected health information. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by either writing to University of Maryland Health Partnersat the address provided below:

University of Maryland Health Partners
Attention: Compliance Department
1966 Greenspring Drive, Suite 100
Timonium, Maryland 21093

Or by calling University of Maryland Health Partners Member Services Department at the telephone numbers provided below:

Local: 410-779-9369
Toll Free: 1-800-730-8530
TTY: 711
Hours of Operation: 8 AM to 5 PM, Monday through Friday

Right to Request Plan's Use and Disclosure of Protected Health Information

I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carry out treatment, payment, and health care operations. I understand that while University of Maryland Health Partners is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement. I understand that University of Maryland Health Partners may refuse me services if I refuse to sign this consent.

Authorization to Use and Disclose My Protected Health Information to individuals I have specifically designated below

This also serves as an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 [45 CFR § 164.508]. It authorizes University of Maryland Health Partners staff to use and/or disclose my protected health information (PHI) with the individual(s) I have listed below for the purpose(s) designated by me. This authorization is valid until such time as I elect to revoke it.

NAME:	Telephone Number	Relationship to Member
_____	_____	_____

Purpose(s) Check those applicable for the individual listed above

☐ Authorized to act as my representative in requesting services and/or payment of claims from the health plan only.

☐ Authorized to make any changes to the demographics in my membership record, including but not limited to address changes, telephone number changes, email address changes, and request for a replacement ID card only.

☐ Authorized to act as my representative in connection with my claim or asserted right under the Code of Maryland Regulations (COMAR), 10.01.04-12, 10.09.71.05, and 10.09.75.05. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals and grievance information; and to receive any notice in connection with my appeal or grievance, wholly in my stead. I understand that personal medical information related to my appeal or grievance may be disclosed to the representative indicated above.

☐ Authorized for all of the above actions

NAME: Telephone Number Relationship to Member

_____ _____ _____

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☐ Authorized for all of the above actions

Right to Revoke This Consent and Authorization

I understand that I have the right to revoke this consent and authorization at any time provided that I do so in writing, but that University of Maryland Health Partners and any other entity working directly with University of Maryland Health Partners for the purposes of carrying out treatment, payment, or health care operations on my behalf may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that University of Maryland Health Partners may refuse me further service if I revoke consent.

_____ _____

Signature of Member Date

_____

Member ID Number (from membership ID card)