Shared Strength · Trusted Care

III-A Authorization to Use or Disclose Protected Health Information

Federal and state laws protect the privacy of your health information. By completing this form, you authorize III-A to use or disclose your protected health information (PHI) to the person or organization listed below.

Member Information

Member Name: _____

Date of Birth: _____

Agency/Employer: _____

Person or Organization Authorized to Receive Information

I authorize III-A to disclose my protected health information to:

Name: _____

Organization (if applicable): _____

Address: _____

Phone/Email: _____

Purpose of the Use or Disclosure

(example: care coordination, benefits assistance, communication with family member)

_____

Information to Be Disclosed

This authorization may include health information such as:

- Medical records
- Claims or billing information
- Care management notes
- Diagnostic test results
- Treatment information
- Pharmacy records
- Health plan enrollment or eligibility information

III-A will disclose only the **minimum necessary information** for the purpose listed above.

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Sensitive Information (Initial if Included)

_____ HIV/AIDS test results or related information

_____ Mental health information

_____ Genetic testing information

_____ Drug or alcohol diagnosis, treatment, or referral information

Additional Authorizations

☐ Allow III-A to discuss my information with my spouse or family member listed above.

☐ Allow the III-A Care Management/Telehealth Providers to coordinate with my healthcare providers regarding my care.

☐ Allow III-A to discuss claims, billing, or benefits with the authorized individual.

Expiration of Authorization*

☐ Expiration Date: _____
* This authorization will remain valid if left blank

Member Rights

I understand that:
• I may refuse to sign this authorization.
• My refusal will not affect my eligibility for benefits.
• I may revoke this authorization at any time in writing, except to the extent that action has already been taken based on it.
• Information disclosed under this authorization may no longer be protected by federal privacy laws if it is re-disclosed by the recipient.

To revoke this authorization, submit a written request to:
III-A
PO Box 190477
Boise, ID 83719
admin@iii-a.org

Signature

I have read and understand this authorization.

Signature: _____

Date: _____

Relationship to Member: ☐ Self ☐ Parent ☐ Legal Guardian* ☐ Power of Attorney*

*Legal documentation must be attached if signing as guardian or power of attorney.