TRIPLE-S SALUD
BlueCross BlueShield of Puerto Rico

## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Purpose: This form is to be used by an individual to authorize TRIPLE-S SALUD to disclose the individual's protected health information. This form can also be used by beneficiaries subscribed to the Healthcare Program of the Commonwealth of Puerto Rico.

### SECTION A: Health Plan Member authorizing use and/or disclosure of Information.

Health Plan Member: Refers to the insured covered under the Triple-S Salud or Medicare Óptimo health plan.

Name: _____

Address: _____

_____

Telephone: _____ E-mail: _____

Contract Number: _____ Social Security number: _____

### TO THE INDIVIDUAL: Please Read.

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan or eligibility for benefits on receiving this authorization.

Effect of Granting this Authorization: The protected health information described below may be disclosed to individuals or entities that are not subject to health information privacy laws, and it may no longer be protected by federal health information privacy laws.

### SECTION B: The disclosure being authorized.

Purpose of this Authorization:

☐ At request of individual (or the individual's personal representative).

☐ Access to personal health information to the parent non guardian[1].

Minor name: _____

☐ Lawsuit

☐ Grievance

☐ Other _____

[1] In case of minor that are under the contract of either parent, the person who authorizes is the principal insured or the parent guardian.

Entities Authorized to Receive the information: Specify the names and demographic information of the individuals or entities authorized by the health plan member to receive and use the protected health information. NOTE: It is important to indicate the effective date and the expiration date. The effective date should be the date the authorization is signed. The expiration date cannot exceed 24 months after the effective date:

1.

Name: _____

Address: _____

_____

Birth Date: _____ Effective Date: _____

Expiration Date: _____

Representative Type:

- ☐ Accountant ☐ Care Facilities ☐ Legally Assigned Tutor
- ☐ Attorney ☐ Family Member ☐ Other_____

Permissions to be granted:

- ☐ Benefits ☐ Coverage Certificate ☐ Reimbursement Status
- ☐ Member Demographics ☐ ID card Duplicate ☐ Change Demographics
- ☐ Claims ☐ Preauthorization Status ☐ No Limits
- ☐ Other _____

2.

Name: _____

Address: _____

_____

Birth Date: _____ Effective Date: _____

Expiration Date: _____

Representative Type:

- ☐ Accountant ☐ Care Facilities ☐ Legally Assigned Tutor
- ☐ Attorney ☐ Family Member ☐ Other_____

Permissions to be granted:

- ☐ Benefits ☐ Coverage Certificate ☐ Reimbursement Status
- ☐ Member Demographics ☐ ID card Duplicate ☐ Change Demographics
- ☐ Claims ☐ Preauthorization Status ☐ No Limits
- ☐ Other _____

**SECTION C: Revocation.**

Right to Revoke: You may revoke this authorization at any time by giving written notice of revocation to the Contact Office listed below. Revocation of this authorization will *not* affect any action we took in reliance on this authorization before we received your written notice of revocation.

Contact Office: COMPLIANCE AND PRIVACY OFFICE

Telephone: (787) 277-6686 Fax: (787) 706-4004

E-mail: privacidad@ssspr.com

Address: PO Box 363628, San Juan, PR 00936-3628

**INDIVIDUAL'S SIGNATURE.**

I, _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, the person must present evidence of the authorization (Medical certificate, Power of attorney specific to protected health information or Appointment of a guardian by a competent court) and complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

**YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.**

**Include this authorization in the subscriber's records.**