ROCKY MOUNTAIN HEALTH PLANS®

Authorization to Use or Disclose Specific Information

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Member Name (Please Print):	Member DOB (mm/dd/yy):
Member ID #:	Member Phone #:

I authorize Rocky Mountain Health Plans (RMHP), its agents or subsidiaries to disclose the individually identifiable health information (PII) and protected health information (PHI) indicated below to the person(s) specified on this form.

I authorize disclosure of the following (choose one):

☐ All health information relating to eligibility, treatment, claims and prescriptions
☐ Only information related to (specify):

The authorized below can make the following change(s):_____

_____

The information may be disclosed to and/or used by:

Name (Print):	Relationship to:	Phone:
Name (Print):	Relationship to:	Phone:
Name (Print):	Relationship to:	Phone:
Name (Print):	Relationship to:	Phone:

This authorization expires (choose one):

☐ When plan terminates (including any gap in coverage)
☐ On this specific date:
☐ When this event occurs (specify):

I understand that I may revoke this authorization at any time by notifying RMHP in writing that I no longer give them permission to disclose information to the person(s) named on this form. I understand this revocation will not apply to information that has been released prior to revocation.

I understand that authorizing the disclosure of health information is voluntary and that I can refuse to sign this authorization. Choosing not to sign will not affect my eligibility or enrollment in a plan. Additionally, choosing not to sign will not affect my ability to receive health care treatment and will not prevent payment for health care benefits to which I may be entitled as a Member of RMHP.

I understand that the person(s) named on this form could tell others about my personal health information that he or she receives. In that case, the laws that RMHP, its agents or subsidiaries follow to protect the information may no longer apply.

Signature: _____ **Date:**_____

☐ Member ☐ Legal Representative

Legal Representative

If someone other than the Member (Legal Representative) signs this form, you must attach copies of authorization to represent the Member. Examples include Power of Attorney or Guardianship papers.

Please complete the following:

Legal Representative Name: _____

Type of Authorization: _____

For help in completing this form, please call our Customer Service at 888-282-1420 (TTY dial 711). Hours are 8am – 8pm, 7 days/week, October 1-March 31, and 8am – 8pm, M-F, April 1-September 30.

Please return this form (and documentation, if applicable) to:

Mail: RMHP
PO Box 10600
Grand Junction, CO 81502-5600

Fax: 970-244-7880
Email: Customer_Service@rmhp.org

RMHP is a Medicare-approved Cost plan. Enrollment in RMHP depends on contract renewal.

Notice of Nondiscrimination

Rocky Mountain Health Plans (RMHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-346-4643 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-346-4643 (TTY: 711).