Authorization for my health plan to share my protected health information

HealthPartners provides medical and dental insurance and services to its members. As a member, you may want to tell us to share some of your information with others. To do so, fill out the form on page two and send it back to us.

What's protected health information?

Because you're a HealthPartners member, we have information that identifies you. This is called protected health information (PHI). It includes health plan information, such as:

- Demographics like your name, address, phone number and date of birth
- Health information like diagnosis and care you received
- Claims and health insurance coverage information

What do I need to do?

Fill out and sign the form on page two if you want HealthPartners to share your PHI with another organization or person(s). Then mail it back to us at:

HealthPartners
Mail Stop 21103R
PO Box 9463
Minneapolis, MN 55440-9463

You can also fax it to us at **952-883-7333**.

Want to fill out this form online? Log on to your *my*HealthPartners account. You can find the form under the "My Plan" tab.

Questions?

Call HealthPartners Member Services at the number listed on your member ID card.

H2422_112268 DHS Approved 9/4/2018

HealthPartners is a health plan that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in HealthPartners depends on contract renewal.

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HealthPartners®

Authorization for my health plan to share my protected health information

Instructions

Fill out and sign this form to authorize HealthPartners to share your PHI with the following organization or person(s).
Then mail it back to us at the address on page one.

Name _____ Date of birth (mm/dd/yyyy) _____

Member ID _____

I give HealthPartners permission to share my PHI with the following organization or person(s). I'm asking HealthPartners to share my information with them to help answer questions and resolve concerns related to my health plan.

Name _____
Street _____
City _____ State _____ ZIP _____
Phone _____ Relationship _____

Name _____
Street _____
City _____ State _____ ZIP _____
Phone _____ Relationship _____

What PHI can HealthPartners share with them? Check all that apply. *Note: Some information may require additional permission.*

- ☐ Membership information, such as your member ID
- ☐ Claims/authorization information, such as claim status and payments
- ☐ Medical management information, such as authorizations and case management information
- ☐ Complaint/appeal information, such as outcome, rationale and medical records
- ☐ FSA/HRA information, such as claim status and payments, and remaining balances
- ☐ Other – please describe: _____

I understand that:

- This permission is good for one year.
- If I want this permission to end **sooner than one year**, that date is: _____ . Or at any time I want, I can cancel this permission by writing to HealthPartners at the address on page one.
- If I cancel this permission, that doesn't affect information that's already been shared.
- Once shared, my PHI may not be protected by state or federal law. The organization or person(s) who receives it could share it with others.
- HealthPartners can't decide whether or not to provide treatment, payment, enrollment or eligibility for benefits based on whether I sign this form.
- I can have a copy of this authorization.
- An electronic copy or photocopy of this signed form is the same as the original.

_____ _____
Signature – yours or your representative's — Date

If signed by your representative, include a copy of documents showing the legal authority of the representative (such as a power of attorney, or court documents appointing guardian or foster parent).

_____ _____
Print representative's name — Relationship to member

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Civil Rights Notice

Discrimination is against the law. HealthPartners does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by HealthPartners. You may file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:

Civil Rights Coordinator
Office of Integrity and Compliance, MS 21103K
HealthPartners
P.O. Box 1309
Minneapolis, MN 55440-1309
1-844-363-8732 (toll free), 711 (TTY), 952-883-5522 (fax)
integrityandcompliance@healthpartners.com (email)

Auxiliary Aids and Services

HealthPartners provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact** 1-866-885-8880.

Language Assistance Services

HealthPartners provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact** 1-866-885-8880.

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by HealthPartners. You may also contact any of the following agencies directly to file a discrimination complaint:

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion (in some cases)

Contact the **OCR** directly to file a complaint:

Office for Civil Rights, U.S. Department of Health and Human Services
Midwest Region
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
Customer Response Center: 800-368-1019 (toll free)
800-537-7697 (TTY)
ocrmail@hhs.gov (email)

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North
Suite 201
St. Paul, MN 55104
651-539-1100 (voice)
800-657-3704 (toll free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

Minnesota Department of Human Services (DHS)

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- religion (in some cases)

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. We will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

1-866-885-8880 (TTY:711)

Attention. If you need free help interpreting this document, call the above number.

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ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တကွ၊်. ဖဲနမ့၊်လိဉ်ဘဉ်တ၊်မၤစၢၤကလီလၢတ၊်ကကျိးထံဝဲဇဉ်လံာ် တီလံာ်မီတခါအံၤန့ဉ်,ကိးဘဉ်လိတဲစီနီ၊်ဂ်၊်လၢထးအံၤန့ဉ်တကွ၊်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງ ໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.