TRIPLE-S ADVANTAGE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Purpose: This form is to be used by an individual to authorize Triple-S Advantage to disclose the individual's protected health information.

SECTION A: INDIVIDUAL AUTHORIZING USE AND/OR DISCLOSURE OF INFORMATION

Name: _____

Address:_____

Telephone: (____)_____ Cellular: (____)_____

Contract Number: _____ Email: _____

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: TYPE OF INFORMATION:

Protected Health Information, including, but not limited to, identification of treating providers of care, diagnosis, procedures, treatment, demographic information, claims for coverage or benefits for any and all medical conditions (but not including psychotherapy notes).

SECTION C: PURPOSE OF THE AUTHORIZATION

I understand that Triple-S Advantage does not disclose my personal health information to other parties, except those directly involved in my care, without my written authorization. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named below for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits. I also understand that if my Authorized Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and my personal representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

☐ Request of the Person ☐ Legal Process ☐ Complaint ☐ Other

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION P.2

Entities Authorized to receive information: List the names and demographic information of the persons or entities authorized to receive protected health information.

1. Name: _____

Address:_____

Date of Birth: _____ Telephone: (____)_____

License Number:_____

Effective Date: _____ Expiration Date: _____

Relationship with the plan member:

☐ Accountant ☐ Care Institution ☐ Court appointed guardian

☐ Lawyer ☐ Family Member ☐ Other: _____

Limitations on Disclosure:

I understand that I have the right to limit information that you release under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health care provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating no limitations to disclosure.

Describe limitations:_____

_____

2. Name: _____

Address:_____

Date of Birth: _____ Telephone: (____)_____

License Number:_____

Effective Date: _____ Expiration Date: _____

Relationship with the plan member:

☐ Accountant ☐ Care Institution ☐ Court appointed guardian

☐ Lawyer ☐ Family Member ☐ Other: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION P.3

Limitations on Disclosure:

I understand that I have the right to limit information that you release under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health care provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating no limitations to disclosure.

Describe limitations:_____

_____

SECTIONS D: EXPIRATION AND REVOCATION

Expiration: This authorization to release information to your Authorized Representative will automatically expire in 24 months or before if you provided a shorter period on the expiration date section.

Right to Revoke: You may revoke this authorization at any time, submitting a written notification of revocation to the Compliance Department. The revocation of the authorization will have prospective effect and will not affect the actions that have taken Triple-S Advantage as the authorization was in effect before the revocation. Notification of revocation must include an effective date, your signature and the date it was signed in order to be processed. Please submit your notification of revocation by email, fax or mail, to:

Contact Office: Privacy Officer
Compliance Department

Address: PO Box 11320
San Juan, PR 00922-9905

Fax (787) 993-3260

Email: hipaacompliance@sssadvantage.com

Telephone: 1-888-620-1919

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION P.4

AUTHORIZATION:

I, _____, have had full opportunity to read and consider the content of this Authorized Representative Form. I confirm that this authorization is consistent with my request to Triple-S Advantage, Inc. I understand that, by signing this form, I am confirming my authorization to Triple-S Advantage, Inc. to use/disclose my protected health information to the person(s) named in above for the purpose described.

Signature: _____ **Date:** _____

Important Information: If this authorization is signed by an authorized representative on behalf of the beneficiary, please complete the information below and include **evidence of authority** (Example: Power of Attorney, Designation of Guardian by Court with jurisdiction.) Note: The document of representation in the Social Security is **Not** admissible for the purposes of this form as an authorized representative.

Personal Representative's Name: _____

Relationship to Individual: _____

Evidence Included: _____

General Requirements to Complete the Authorization for Disclosure of Protected Health Information Form.

- The signature and authorization date are required for the document to be valid.
- If evidence of an authorized representative is not included, the document will not be considered complete.
- If the Authorization Form is not completed correctly, it becomes invalid. This situation may cause a delay in our good services.

Triple-S Advantage is firm in compliance with state and federal regulations related to the privacy of protected health information of our members.

Triple-S Advantage, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Triple-S Advantage, Inc. cumple con las leyes federales aplicables de derechos civiles y no discrimina por razón de raza, color, origen de nacionalidad, edad, discapacidad, o sexo.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call: 1-888-620-1919 (TTY: 1-866-620-2520).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística están disponibles libre de cargo para usted. Llame al: 1-888-620-1919 (TTY: 1-866-620-2520).