AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION FORM

This form authorizes VSP Global® (VSP®) to use or disclose your information to a third party over the telephone on your behalf as you designate below. VSP will not disclose information collected on this form to any source other than what has been authorized under the HIPAA Privacy Rule (45 CFR Parts 160 and 164), which includes purposes of treatment, payment, and healthcare operations or as required by law.

Section 1 – Member Requesting Authorization to Use or Disclose Protected Health Information (Please print clearly)			
1. First Name:	Middle Name/Initial:	Last Name:	
2. Address or PO Box:	City:	State:	ZIP:
3. Member ID Number:	4. Social Security Number*:	5. Date of Birth (MM/DD/YYYY):	
6. Email (if available):	7. Cell Phone Number:	8. Daytime Phone Number:	

*Member ID number OR Social Security number required.

Section 2 – Authorized Individual/Organization to Use or Receive Protected Health Information			
If authorization is for an organization, please provide the first and last name of the organization's representative.			
9. Organization Name (if applicable):			
10. First Name:	Middle Name/Initial:	Last Name:	
11. Address or PO Box:	City:	State:	ZIP:
12. Email (if available):	13. Cell Phone Number:	14. Daytime Phone Number:	

Section 3 – Health Information to be Used and/or Disclosed

Specify the health information to be released and/or used:

- ☐ All my past, present, or future health claims, claims adjudication, eligibility information, and provider information.
- ☐ All my health information relating to date of service: _____
- ☐ My health information limited to prescription lens/eye care.

Note: This authorization excludes disclosure of any information related to substance abuse, mental health, HIV diagnosis/treatment, and genetic information.

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- I understand I may revoke this authorization, except for actions already taken on my behalf, based on this authorization, at any time by sending a request in writing to VSP at the address listed below.
- I understand payment, enrollment, or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.
- I am aware of my right to receive a copy of this authorization upon request.
- I understand information disclosed pursuant to this authorization could be redisclosed by the recipient. Such re-disclosure may not be prohibited by law and may no longer be protected by federal privacy regulations (HIPAA).
- I understand the completion of this form does not allow a third party to manage my care.

If a member's representative signs the authorization, attach documentation of the representative's authority (for example, power of attorney).

Section 4 – Terms of Release of Protected Health Information

From the date of signing below until: _____
Please specify date, month, and year (not to exceed 24 months)

If no expiration date is specified, this authorization will expire 24 months from date of signature.

Section 5 – Signature

_____ _____
Signature of person giving authorization | Date signed

_____
Print name of person giving authorization

You should make a copy of your signed authorization for your records before sending it to VSP.
Return completed form and any related documentation to: VSP Attn: Privacy Requests 3333 Quality Drive MS-321 Rancho Cordova, CA 95670 or HIPAA@vsp.com.

VSP Use Only

Status	Signature	Date of Review
☐ Approved		
☐ Denied/Reason for Denial: ☐ Missing Signature/Incomplete ☐ No Supporting Documents ☐ Requester is Not a Member ☐ Other: _____		

Prohibition on redisclosure: Further disclosure of information by the appointed representative may only be made in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and applicable federal/state laws.
This document may contain information covered under HIPAA and its various implementing regulations and must be protected in accordance with those provisions. If you have received this correspondence in error, please notify VSP at **916.858.7432** immediately, then destroy the document and any copies you have made.