Authorization to Share Personal Health Information (ASPI)

WHAT IS THE PURPOSE OF THIS FORM?

You may use this form to grant permission to Bright HealthCare or one of its affiliates to share your Personal Health Information (PHI) with a person or organization of your choice. Bright HealthCare may use this form to obtain your permission to request your PHI from a specific third-party, such as a previous insurance carrier or a non-participating provider.

FREQUENTLY ASKED QUESTIONS

How long does the permission last?

Permission to share your PHI ends on your last day as a member of the plan, or when you let us know in writing that you wish to end your permission.

How do I end permission to share my PHI?

You will need to write us (with signature and date) to the address below and retain a copy for your records.

What if I refuse to sign this form?

You are not required to sign this form – your health benefits will not be affected.

What happens to my health information after Bright HealthCare shares it?

Bright HealthCare takes your private information very seriously. Bright HealthCare shares this information only with the persons and for the purposes authorized on this form. However, we can't control what happens to your information after we share it with the person or organization you name on this form.

Send completed form to:

Bright HealthCare
P.O. Box 1697
Portland, ME 04104
Fax: **877-587-9134**

Authorization to Share Personal Health Information

MEMBER INFORMATION (*Required)

Full Name: ____________________ Member ID: ____________________

TYPE AND AMOUNT OF INFORMATION TO BE SHARED (*Required)

The type and amount of information that I am authorizing to be shared is:

☐ Medical claims information
☐ Pharmacy claims information
☐ Information on authorizations or appeals*
☐ Other (describe): ____________________
☐ Everything, except: ____________________

PERMISSION TO SHARE MY PERSONAL INFORMATION

I authorize ____________________ (Bright HealthCare or Provider name) to share the above-indicated records with ____________________ (Person at Organization/Entity) at ____________________ (Address).

EXPIRATION AND REVOCATION OF AUTHORIZATION

I understand that my authorization will remain in effect until my last day of coverage or until ___ /___ /_____ (date), whichever is earlier. I understand that I can revoke/cancel this authorization at any time by sending a letter to Bright HealthCare. I understand that this revocation will not apply to information that has already been released in response to my initial authorization.

RIGHT TO RETAIN A COPY OF THE AUTHORIZATION

I understand that I have the right to retain or receive a copy of this authorization form.

YOUR PERMISSION (*Required)

Signature: ____________________ Date: ___/___/_____

☐ Check if you are Parent/Legal Guardian, or Authorized Representative/Power of Attorney (please include documentation with this form)

Note – When you sign this form, you agree to the following: Bright HealthCare and its related companies have permission to share my personal health information to the person or organization listed in the section above, and/or request my personal health information from a specific third-party. I understand that requested records may contain information on specific medical care or claims. They may also contain information created by others.

*This authorization does NOT allow the named delegate to act on my behalf relative to healthcare decisions, appeals, grievances, or enrollment.