Authorization for the Use and Disclosure of Protected Health Information (PHI)

SECTION 1: Member Information *(Person whose information will be disclosed/used)*

First Name: _____ Last Name: _____

Member ID: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

I understand that this Authorization for the Use and Disclosure of PHI will allow Sonder Health Plans to release my Protected Health Information (PHI), including medical, dental, and pharmacy information, as I authorize below:

☐ All Protected Health Information (PHI) - clinical, claims, billing, benefit, and coverage information
Selecting this indicates I am authorizing the release of behavioral health, HIV, and substance use information, unless I have identified restrictions in SECTION 2 of this Form below.

☐ Other (specify here): _____

***SECTION 2:** Restrictions *(Select all that apply, if any)*

I restrict the following type of PHI from being disclosed under this Authorization:

☐ Mental Health ☐ HIV ☐ Substance Use

SECTION 3: Authorized Individual Information *(Person who is being authorized to access PHI)*

I authorize information, as indicated above, to be disclosed to the following:

First Name: _____ Last Name: _____

Relationship: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

I understand that unless otherwise revoked, this authorization will expire 12 months from the date of my signature. I understand I have the right to revoke this authorization at any time and that if I revoke this Authorization, I must do so in writing and present my written request to Sonder Health Plans' Member Services Department. I understand that the revocation will not apply to information that has been released in response to this authorization and that after information is disclosed under this authorization, it can be redisclosed by the recipient and the information may not be protected by federal privacy regulations. I understand I do not have to sign this Authorization, and that Sonder Health Plans can not and will not base treatment or payment decisions on whether I sign this Authorization. I understand that a copy of this Authorization may be utilized with the same effectiveness as an original and that I am entitled to receive a copy of this Authorization.

_____ _____

Member or Legal Representative Signature Date

If Legal Representative signs, must provide documentation to support legal authority to act on behalf of Member.

If Authorized by a Legal Representative, Print Name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____