Authorization for Disclosure of Protected Health Information Form

(866) 624-6261
Quartz-member@brightonhps.com

Purpose: This form is used when you want to give another person access to your protected health information. For example, you would use this form if you want someone other than yourself to regularly discuss your claims with us (such as your child or an insurance agent).

I. Individual authorizing use and/or disclosure

Name:	Participant ID Number:	
Street Address:		
City:	State:	ZIP:
Date of Birth (MM/DD/YYYY):	Telephone Number:	

II. The use and/or disclosure being authorized

I hereby authorize Quartz to disclose the following protected health information:

☐ Claims Summary ☐ Appeal ☐ Enrollment Records ☐ Prior Authorization

☐ Other (please specify): _____

Disclose Protected Health Information to:

Name of Individual/Organization:		
Street Address:		
City:	State:	ZIP:
Telephone Number:	Fax Number:	

III. Individual's signature

Right to Refuse to Sign this Authorization: I understand that I am under no obligation to sign this form and that my health plan may not condition treatment, payment or eligibility for health care benefits on my decision to sign this authorization.

Right to Revoke this Authorization: I understand written notification is necessary to revoke this authorization. To obtain information on how to revoke my authorization, I may contact the Quartz Plan Administrator (see below for contact information). I am aware that my revocation will not be effective until received by Quartz. I understand that my revocation will have no effect on disclosures made prior to Quartz's receipt of my revocation.

Redisclosure Notice: I understand once Quartz, on behalf of my health plan, discloses my information based on this authorization, this information may no longer be protected by federal and state privacy standards and that my health information may be re-disclosed without obtaining my information.

Expiration: This authorization will expire 24 months from the date signed, unless I specify an earlier date or event here: _____. I have had an opportunity to review this authorization form. I understand the content of this authorization form. By signing this authorization form, I am confirming that it accurately reflects my wishes. I am entitled to keep a copy of this form for my records.

Your Signature/Your Personal Representative's Signature:

Your Name (printed):	Date:

If a Personal Representative has signed this form, please attach appropriate documentation verifying legal authority, such as Guardianship or Power of Attorney Documents, if applicable.

Return this form to: Quartz Align
c/o Brighton Health Plan Solutions
P.O. Box 8085
Garden City, NY 11530

Fax: **(516) 723-7390**
Phone: **(866) 624-6261**