



Health Insurance Portability and Accountability Act of 1996

Authorization for Release of Information Pursuant to HIPAA

Privacy Rule

The HIPAA Privacy Rule establishes a foundation of Federally-protected rights which permit individuals to control certain uses and disclosures of their protected health information. Along with these rights, the Privacy Rule provides individuals with the ability to access and amend this information, and the right to an accounting of certain disclosures. Marpai recognizes that there may be times when individuals are legally or otherwise incapable of exercising their rights, or simply choose to designate another to act on their behalf with respect to these rights. Under the Rule, a person authorized (under State or other applicable law, e.g., tribal or military law) to act on behalf of the individual in making health care related decisions is the individual's "personal representative." Section 164.502(g) provides when, and to what extent, the personal representative must be treated as the individual for purposes of the Rule. In addition to these formal designations of a personal representative, the Rule at 45 CFR 164.510(b) addresses situations in which family members or other persons who are involved in the individual's health care or payment for care may receive protected health information about the individual even if they are not expressly authorized to act on the individual's behalf.

Instructions for Completing the ROI Form

1. Form is Adobe fillable or print and fill. Please print legibly in all fields using dark permanent ink.
2. *Section I*, print your name or the name of member/dependent whose information is to be released.
3. *Section II*, provide the name, address, email, contact information and relationship of the person and/or facility that will discuss or receive the information (*required*).
4. *Section III*, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, personal use, etc.
5. *Section IV*, check the appropriate box(es) as they apply to your release of information or appointed personal representative. **Date range or all dates is required.*
 - a. **Only information related to (required)**-- specify diagnosis, injury, operations, special therapies, etc.
 - b. **Only the period of events from** -- specify date range, e.g., Jan. 1, 2023, to Feb. 1, 2023.
 - c. **Other (specify)** -- e.g., CPS, Billing, Employee Health.
 - d. **Entire Record** -- complete record including, if authorized, the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes).
 - e. **IN ORDER TO RELEASE SENSITIVE INFORMATION REGARDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), THE APPROPRIATE BOX OR BOXES MUST BE CHECKED BY THE PATIENT.**
 - f. **Psychotherapy Notes ONLY**
IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.
IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. *These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider, thus in turn the need for an additional ROI form.*
6. *Section V*, if no expiration date or a different expiration date is desired, specify a new date or no expiration.
7. *Section V*, Please sign and date.
8. A copy of the completed Marpai ROI form will be provided to you upon request.

Marpai Inc. Privacy and Security Contact:

Bridget Stockdill, OHCC, CHCO, CORCM, CPC
Privacy and Security Officer, Certified

Email: compliance@marpaihealth.com

Member ID _____



Complete All Sections, Date, and Sign

I. I, _____, hereby voluntarily authorize the disclosure of information from my health record.
Member/Patient/Dependent Name

II. The information is to be provided to: _____
Name of Personal Representative, Facility, Attorney, etc

Address

City and State _____ Zip Code _____

Phone Number _____ Relationship to Member _____

Email Address _____

III. The purpose or need for the disclosure is: [check the appropriate box(es)]

- | | | |
|---|-------------------------------------|---|
| <input type="checkbox"/> Continuation of Care | <input type="checkbox"/> Insurance | <input type="checkbox"/> Research |
| <input type="checkbox"/> Personal Use | <input type="checkbox"/> School | <input type="checkbox"/> Other (<i>Specify</i>) _____ |
| <input type="checkbox"/> Attorney | <input type="checkbox"/> Disability | _____ |

IV. Information to be disclosed from my health record: [check appropriate box(es)]

- Entire Health Record **All Date(s) (for a specific date range see below)*
- Only information related to (*specify below*) _____

- *Only the period of events from _____ to _____
- Other (*specify below*) _____

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

- | | |
|--|--|
| <input type="checkbox"/> Alcohol/Drug Abuse Treatment/Referral | <input type="checkbox"/> HIV/AIDS Related Treatment |
| <input type="checkbox"/> Sexually Transmitted Diseases | <input type="checkbox"/> Mental Health (<i>Other than Psychotherapy Notes</i>) |
| <input type="checkbox"/> Psychotherapy Notes ONLY (<i>by checking this box, I am waiving any psychotherapist-patient privilege</i>) | |

V. This Authorization will expire One Year after the termination of enrollment in the health plan or One Year after the termination of Marpai administering the health plan, whichever occurs first.

You have the right to set your own expiration date other than that stated above. _____
(Specify New Date)

If you do not want this authorization to expire, please check the following box: No Expiration Date

This form is used to appoint or revoke an individual or organization to access your health information. If you wish to authorize a person to discuss or receive your PHI, please complete the above fields.

PHI will NOT be disclosed to anyone other than the patient, unless this Authorization form is completed, providing the required information to disclose protected health information. An Authorization form must be filled out for each person you wish to receive your PHI.

I understand that I may revoke this authorization in writing submitted at any time to compliance@marpaihealth.com, except to the extent that action has been taken in reliance on this authorization.

In addition, an Authorization must be completed by each of your adult dependents to disclose any information.

The Privacy Rule generally allows a parent to have access to the medical records about his or her child, as his or her minor child's personal representative, when such access is not inconsistent with State or other law.

There are three situations when the parent would not be the minor's personal representative under the Privacy Rule.

These exceptions are:

- When the minor is the one who consents to care and the consent of the parent is not required under State or other applicable law;
- When the minor obtains care at the direction of a court or a person appointed by the court; and
- When, and to the extent that, the parent agrees that the minor and the health care provider may have a confidential relationship.

However, even in these exceptional situations, the parent may have access to the medical records of the minor related to this treatment when State or other applicable law requires or permits such parental access. Parental access would be denied when State or other law prohibits such access. If State or other applicable law is silent on a parent's right of access in these cases, the licensed health care provider may exercise his or her professional judgment to the extent allowed by law to grant or deny parental access to the minor's medical information.

Finally, as is the case with respect to all personal representatives under the Privacy Rule, a provider may choose not to treat a parent as a personal representative when the provider reasonably believes, in his or her professional judgment, that the child has been or may be subjected to domestic violence, abuse or neglect, or that treating the parent as the child's personal representative could endanger the child.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule of 1996 [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

I further understand that if the persons I authorize to receive my PHI are not health plans, covered health care providers or health care clearinghouses subject to the Health Insurance Portability and Accountability Act (HIPAA) or other federal information privacy laws, they may further disclose the PHI and it may no longer be protected by HIPAA or federal health information privacy laws.

 Member/Patient/Dependent

 Date

 Guardian or Personal Representative

 Date

(Please attach the legal document (e.g. power of attorney, court order, etc) describing your authority to act on behalf of the member/patient/dependent)