Do you want us to share your health information with someone?

NEW DIRECTIONS®

Fill out the form to name an authorized delegate

What is the purpose of this form?
This form allows New Directions Behavioral Health to share information about your healthcare account with someone else for the purpose of coordination of care. For instance, you might want us to share your private healthcare information with your spouse, another family member, your child's guardian, your employer, or a parent.

If you fill out and sign this form, we will share your claims, benefit, and health information with anyone you choose. The person or organization you choose becomes your *authorized delegate*. Your authorized delegate can only receive information. They cannot take action on your behalf or change anything about your health insurance policy or benefit plan.

If you do not wish to fill out this form, we will continue to serve you. However, we will not be able to share your information. Once we receive your completed form, we can share your information with your authorized delegate for one year unless otherwise specified or revoked.

If this authorization covers a minor child, it will end on that child's 18th birthday.

Does this form allow your authorized delegate to receive a copy of your medical record?
No. To obtain a copy of your medical record, please complete and submit the Authorization to Disclose Protected Health Information form. It can be found by clicking here or visiting: https://www.ndbh.com/Home/HIPAA

Verbal approval is temporary.
If you have called us to name an authorized delegate and have received temporary approval from us, you must fill out and sign this form so that your authorized delegate can continue to receive information from us. Your verbal approval is only valid for **24 hours** after we talk to you.

After you complete this form, send it to us:

Email: _____

Fax: _____

Mail: New Directions Behavioral Health
PO Box 6729
Leawood, KS 66206
Attn: Contact Center

Can you change your decision?
Yes, you may change your decision about sharing your information at any time. If you decide that you no longer want us to share your information with an authorized delegate, please contact New Directions at the toll-free number listed on the back of the member's insurance card. Changing your decision does not affect actions that New Directions took while this authorization was valid.

If you still have questions, call us at the toll-free number listed on the back of the member's insurance card.

Call us. We are happy to help.

Name an Authorized Delegate

NEW DIRECTIONS®

This form authorizes New Directions to share your information with someone else for the purpose of coordination of care. If you do not wish to fill out this form, we will continue to serve you. However, we will not be able to share your information with your authorized delegate.

PART 1: MEMBER WHOSE INFORMATION WILL BE SUBJECT TO DISCLOSURE

Name of Member as shown on ID card

Member Date of Birth

Address

City, State, Zip

Member ID number as shown on ID card

PART 2: AUTHORIZED DELEGATE

We understand that you want to name the following person(s) or organization as your authorized delegate. Note: If the people or organizations you name are not required to follow the federal health information privacy laws, they may share your information with someone else and federal privacy laws may no longer protect your information.

To name a person

If your authorized delegate is a person, fill out this section.

Person's Name

Address

City, State, Zip

Date of Birth (MM/DD/YYYY)

Phone Number

To name another person

If your authorized delegate is a person, fill out this section.

Person's Name

Address

City, State, Zip

Date of Birth (MM/DD/YYYY)

Phone Number

To name an organization

If your authorized delegate is an organization, fill out this section.

Organization's Name

Address

City, State, Zip

Phone Number

PART 3: INFORMATION TO BE SHARED (Please check only one box)

☐ All information about eligibility, enrollment, plan benefits, claims, correspondence to or from New Directions and prior authorization or determinations for services provided by any physician or hospital, INCLUDING alcohol and substance use information.

☐ All information about eligibility, enrollment, plan benefits, claims, correspondence to or from New Directions and prior authorization or determinations for services provided by any physician or hospital, EXCLUDING alcohol and substance use information.

☐ Only specific information: _____

PART 4: SIGN HERE IF YOU ARE THE MEMBER

By signing here, you give New Directions permission to share any of your personal information that is protected by federal or state law with the authorized delegate(s) named in Part 2 of this form. You understand that this personal information may include detailed medical information about you, including information about substance abuse and mental health conditions if you have approved it in Part 3 of this form. That information does not include psychotherapy notes, HIV information, or genetic information.

This authorization is valid for one year unless otherwise specified or revoked. If this authorization covers a minor child, it will end on that child's 18th birthday. You may change your decision about sharing your information at any time. Changing your decision does not affect actions that New Directions took while this authorization was valid.

Member Signature

Today's Date (MM/DD/YYYY)

PART 5: SIGN HERE IF YOU ARE THE PERSONAL REPRESENTATIVE FOR THE MEMBER

To show that you are legally designated as the member's representative, when you send us this form you must also send us copies of any legal documents that prove you have guardianship or power of attorney.

- I am authorized as a personal representative for the member who is named in Part 1 of this form. I am legally designated as a parent of a minor, legal guardian, or holder of power of attorney.
- I understand that this authorization will be valid as long as the member's health insurance with New Directions is in effect. If the insurance is canceled, the authorization will end.
- If this authorization covers a minor child, it will end on that child's 18th birthday.

Print Name of Personal Representative

Personal Representative Signature

Today's Date (MM/DD/YYYY)

Relationship to Member