Authorization to Disclose Protected Health Information

In order for Oscar to disclose to another person your Protected Health Information you must complete this authorization form and return it to us. You can return this form by scanning or taking a picture of the completed form and sending it to help@hioscar.com. Or mail the completed form to the following address:

CA members: Oscar Insurance, Attn: Oscar Privacy Officer at P.O. Box 1279, CA 90232.

All other members: Oscar Insurance, Attn: Oscar Privacy Officer at P.O. BOX 52146, Phoenix, AZ 85072-2146.

Full name: _____ Oscar ID #: _____ DOB: ____/_____/_____

Who would you like to authorize access to your health information (specify at least one)?

Name: _____ Relationship: _____ Phone #: _____-_____-_____

Name: _____ Relationship: _____ Phone #: _____-_____-_____

Name: _____ Relationship: _____ Phone #: _____-_____-_____

What information do you want disclosed?

If you'd like to authorize any or all information (including mental health, HIV and AIDS, alcohol/drug abuse treatment, abortions records), no selection is required.

If you prefer not to share certain health information, you can specify which information you'd like to keep private below (selections will not be shared with your authorized person(s)).

- ☐ Mental health records
- ☐ Sexually transmitted diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Abortion/reproductive rights records

How long do you want this authorization to be in effect?

☐ Until the date my Oscar coverage is terminated.

– OR –

☐ This authorization should expire on: ____/_____/_____ (MM/DD/YYYY)

If no expiration is specified, this authorization will expire 1 year from the date that you sign this form.

Conditions of Authorization: I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the authorized people listed above and may no longer be protected by the rule.

Revocation/ Cancellation: I have the right to revoke (cancel) this authorization at any time by sending a written notice to Oscar's Privacy Officer at the address listed at the top of this form. Cancellation is effective upon receipt of this form by Oscar's Privacy Officer. Revocation/cancellation will not affect any action taken by Oscar in reliance on this authorization prior to reciving my written notice of cancellation. If I refuse to sign this form, my benefits, coverage, and any payments will not be affected.

Signature required: I have read and understood the terms of this form, and have been given a copy.

Your signature: _____ Date: ____/_____/_____

Note: This form must be signed by either the member or his/her personal representative. If you are not the member, please sign below and indicate your relationship by checking the appropriate box.

Representative signature: _____ Date: ____/_____/_____

Relationship: ☐ Parent ☐ Legal Guardian* ☐ Power of Attorney* ☐ Other*

*Documentation must be provided supporting your legal authority to act on the member's behalf.

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