sidecar health.

Authorization to Disclose Protected Health Information

The Sidecar Health Notice of Privacy Policy (NOPP) explains how we protect your protected health information (PHI).

This authorization documents your intent to identify the person(s) who have your permission to contact us on your behalf ("authorized representative") to receive your PHI for claims status, benefit information, and/or other matters pertaining to your insurance coverage. An authorized representative does not have authority to make changes to your account or exercise rights on your behalf as a legal representative would.

In most instances, the NOPP permits us to share your PHI with health care providers (e.g., physicians, hospitals, etc.) involved in your treatment or payment for your treatment. Therefore, it is not necessary to name your health care providers as authorized persons.

Member Information:

Full Name	
Address	
Date of Birth	

Authorized Representative(s) Information:

I authorize the following person(s) to act as my authorized representative to access my health information as of the signature date on this form:

Full Name	
Relationship	
Address	
Phone Number	

Full Name	
Relationship	
Address	
Phone Number	

Scope:

Sidecar Health may share or request all claim, enrollment and health related information with my authorized representative except as specified below. I'd like to keep specific conditions private (**select any/all that apply**):

- ☐ Mental health
- ☐ Sexually transmitted infections (including HIV and AIDS)
- ☐ Substance use
- ☐ Reproductive health
- ☐ Specify any other limitation to what we may disclose to your authorized representative, as needed:

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Term:

How long should this authorization be in effect? (**select one**)

☐ Until the date my Sidecar Health coverage ends

☐ Until an expiration date of: ____________________________

Acknowledgement:

By signing below, I acknowledge the following:

- I have the right to revoke (cancel) this authorization at any time by notifying Sidecar Health in writing via email or mail. Revocation is effective upon receipt of the notice.
- My authorization is voluntary and not a condition of enrollment, eligibility, or claim payment.
- The authorized person(s) may not be subject to federal/state privacy laws and they may further release my PHI. Sidecar Health is not responsible for further disclosure by my authorized representative.

Signature:	Date:

The member's signature is required. If the member is incapable of signing due to illness, injury, or death, a personal representative, such as the parent of a minor child, power of attorney, or executor, may sign his or her name may sign on the member's behalf. **Legal documentation proving authority to act for the member must be attached**; otherwise, this authorization will not be honored. My relationship to the member named above is:

☐ Member ☐ Power of Attorney or other legal representative ☐ Parent/Guardian ☐ Other

You may submit this completed form to Sidecar Health via email to membercare@sidecarhealth.com or mail to Sidecar Health Member Care, 340 S. Lemon Ave., Suite 7028, Walnut, CA 91789