Authorization for Disclosure of Health Information

This form is used to authorize the disclosure (sharing) of your protected health information (PHI). That means, by signing this form, you allow AmeriHealth Caritas VIP Care Plus (Medicare-Medicaid Plan) to share your PHI with the person(s) or organization(s) you list below. You can also choose to allow those person(s) and organization(s) to share your PHI with us.

PHI is information that relates to your physical and/or mental health. It includes your health at every stage in your life. This includes your past, present, and future health. PHI may also relate to a specific health condition or health service you received. It includes all information regarding your health evaluations, diagnoses, treatments, and/or prescription records. Sharing this type of information may identify you to others. Federal and state laws limit the sharing of PHI.

Even if you sign the form, you can still change your mind about sharing your PHI. Just let us know. You can tell us by mailing a letter to our office. Please include the date, your name, your member ID number, and your current address in the letter. Our mailing address is:

AmeriHealth Caritas VIP Care Plus
Consent Processing Center
P.O. Box 7092
London, KY 40742-7092

Once we receive the letter, we will stop sharing your PHI. However, we cannot take back any PHI we have already shared. If you have questions, contact Member Services by phone at **1-888-667-0318 (TTY 711)**, seven days a week, 8 a.m. – 8 p.m., or by fax at **1-855-226-7301**.

Section A. Member information

Tell us the person whose PHI can be shared.

First name:		Middle initial:
Last name:	Member ID number:	
Date of birth (MM/DD/YYYY): / /		
Address line 1:		
Address line 2:		
City:	State:	ZIP code:
Home phone number (including area code): ( ) -		
Mobile phone number (including area code): ( ) -		
Email address:		

Section B. Recipient information

Tell us the person or organization who can receive your PHI. You can attach more pages, if necessary.

Please tell us if the individuals and/or organizations listed below can also share your PHI with us: ☐ Yes ☐ No

First name of person or organization:		
Middle initial:	Last name:	
Home phone number (including area code): ( ) -		
Mobile phone number (including area code): ( ) -		
Fax number (if available): ( ) -		
Address line 1:		
Address line 2:		
City:	State:	ZIP code:
Email address:		

First name of person or organization:		
Middle initial:	Last name:	
Home phone number (including area code): ( ) -		
Mobile phone number (including area code): ( ) -		
Fax number (if available): ( ) -		
Address line 1:		
Address line 2:		
City:	State:	ZIP code:
Email address:		

First name of person or organization:		
Middle initial:	Last name:	
Home phone number (including area code): ( ) -		
Mobile phone number (including area code): ( ) -		
Fax number (if available): ( ) -		
Address line 1:		
Address line 2:		
City:	State:	ZIP code:
Email address:		

Section C. Sharing of psychotherapy notes

Tell us if your psychotherapy notes can be shared. **(If you check "yes," you may not check a box in Section D. You will need to fill out another copy of this form to authorize sharing of additional PHI in Section D.)**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides special protections for certain medical records known as "psychotherapy notes." These are notes from a mental health professional about conversations during a counseling session. Federal law requires a separate authorization to share psychotherapy notes.

☐ No, do not share my psychotherapy notes.

☐ Yes, please share my psychotherapy notes.

Section D. Sharing of other PHI

Tell us what types of PHI can be shared. **You can check as many boxes as you want. At least one box must be selected.**

☐ **Entire record.** All PHI related to the provision of and payment for my health care benefits and services. **This excludes psychotherapy notes.**

☐ **Special records.** Some laws require you to give specific permission to share certain PHI. Please check the boxes below for PHI that is OK to share. By checking these boxes and writing your initials, you give permission for all your records containing that type of PHI to be shared. If you only want to authorize sharing of a subset of records, such as records about only one diagnosis, fill out the **Other record requests** section below.

☐ Genetic information	Initials:
☐ HIV/AIDS	Initials:
☐ Substance or alcohol use	Initials:
☐ Mental/behavioral health (including inpatient treatment)	Initials:

☐ Sexually transmitted disease	Initials:
☐ Abortion and family planning	Initials:
☐ Communicable diseases	Initials:
☐ Information you have asked us to treat confidentially	Initials:

☐ **Other record requests.** In the box below, describe the PHI you want shared.
Examples:

- The claim related to my service on [date].
- Appeal information related to my claim on [date].

Please describe the information you want shared:

Section E. Purpose of sharing PHI

Tell us why you are releasing your PHI. **At least one box must be selected. If you request the sharing of genetic information to a Louisiana insurer, this authorization shall be invalid if used for any purpose other than as described below.**

☐ Care management/case management and coordination.	☐ Legal purposes.
☐ Billing or claims.	☐ School.
☐ Disability determination.	☐ Housing or other placement services.
☐ Employment.	☐ Other (please describe):
☐ Personal use.	

Section F. Expiration

Tell us when you want this form to expire. **At least one box must be selected.**

This authorization is effective immediately. But you can tell us when you want it to end. You can change this choice at any time.

☐ I want the authorization to expire one (1) year after my coverage with AmeriHealth Caritas VIP Care Plus ends.

☐ I want the authorization to expire on the following date, event, or condition: ___________________________

*AmeriHealth Caritas VIP Care Plus must be notified of the event or condition to cancel or revoke this authorization. If you are requesting the sharing of genetic information to a Louisiana insurer, the expiration date must be within 60 days after the date of the authorization. If you are requesting the sharing of mental health information in the District of Columbia, the expiration date must be within 365 days from the date of the authorization.

Section G. Rights and understandings

By signing below, you acknowledge that you have read and received a sufficient explanation of this document, and that you understand the following information and what you are authorizing us to do with your PHI:

- Any PHI shared may be further shared by the recipient(s) and may no longer be protected by state or federal privacy regulations.
- You may revoke this authorization at any time. However, any action already taken cannot be reversed, and your revocation will not affect those actions. If you revoke this authorization, you should also tell the individuals and organizations listed in Section B.
- Signing this authorization to share PHI is voluntary and is not a condition of enrollment in AmeriHealth Caritas VIP Care Plus, eligibility for benefits, or payment of claims.
- Federal and state laws may allow us to charge a fee for copying records. You may be required to pre-pay for the copies. If not, your copies may be mailed with an invoice.
- You have the right to inspect the materials shared in accordance with this authorization.
- In some cases, federal and state law permit sharing of your PHI without an authorization. For more information, see our Notice of Privacy Practices.
- You can have a copy of this completed form.

If you need more information, please call Member Services at **1-888-667-0318 (TTY 711)**, seven days a week, 8 a.m. – 8 p.m.

Section H. Approval

You or your personal representative must sign and date this form.

☐ I am the member.

By signing below, I authorize the sharing of my PHI as described above.

Member first name:	Middle initial:	Last name:
Member signature:		Date (MM/DD/YYYY): / /

☐ I am the personal representative.

Signing for another person?

A personal representative is a person who has the legal authority to act on behalf of an individual. A copy of a power of attorney or other legal documentation must be on file at AmeriHealth Caritas VIP Care Plus or submitted with this form.

Personal representative first name:	Middle initial:
Last name:	
Description of representative's authority:	
Personal representative signature:	
Date (MM/DD/YYYY): / /	
Home phone number (including area code): ( ) -	
Mobile phone number (including area code): ( ) -	
Email address:	

Type of documentation you are attaching:	
☐ Power of attorney for health care decisions ☐ Legal guardianship ☐ Custodial order ☐ Executor of estate	☐ Other (please specify):

Return the completed authorization form to:

AmeriHealth Caritas VIP Care Plus
Consent Processing Center
P.O. Box 7092
London, KY 40742-7092

Addendum to Authorization for Disclosure of Health Information

Verbal consent

We, the undersigned, attest that the member identified in Section A above is **physically unable** to sign this authorization. Verbal consent does not replace the need for documentation showing that another person is the member's personal representative, and cannot replace this documentation simply because it is inconvenient for the member to sign. Reason: The signatures below indicate: • The information on this form was communicated to the member. • The member indicated their understanding of the information in this authorization. • The member freely gave their consent.	
Method of communication to member: ☐ Phone ☐ In person ☐ Other (specify):	
Witness printed name:	
Witness printed name:	
Witness signature:	
Witness signature:	
Date: / /	Date: / /

AmeriHealth Caritas VIP Care Plus is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-667-0318 (TTY 711)** de 8 a.m. a 8 p.m., los siete días de la semana. La llamada es gratuita.

تنويه: إذا كنت تتحدث العربية، تتوفر خدمات المساعدة اللغوية لك مجانًا. يُرجى الاتصال بالرقم **1-888-667-0318 (TTY 711)**، من 8 صباحًا إلى 8 مساءً، سبعة أيام في الأسبوع. المكالمة مجانية.