Member Authorization

TO **RELEASE/DISCLOSE** PROTECTED HEALTH INFORMATION

NOTE: Incomplete forms cannot be processed and may be returned to you for completion. Please call (855) 969-5861 or TTY 711 if you need assistance or have questions.

The following elements are required in order for CommuniCare Advantage to process your request.

Member Information			
Member Name			
Member ID Number		Home Address	
Date of Birth		Phone Number	

Information Authorized to be Released/Disclosed: I hereby authorize CommuniCare Advantage to release/disclose the health information described below to the "Recipient" identified below for the specified purpose.	
Health information to release/disclose (be specific, including types of information and dates)	
Name of Recipient (person or entity authorized to request and receive protected health information)	
Purpose (provide a specific purpose)	

Protected Categories: If your information includes any of the following types of protected categories, CommuniCare Advantage will NOT disclose such information UNLESS you specifically authorize us to release/disclose the information to Recipient by providing your initials next to the protected category.					
Abortion		Behavioral Health		HIV	
AID/ARC		Genetic Testing		Physical Abuse	
Alcohol and Substance Abuse		Domestic Violence		Reproductive Health	
Sexually Transmitted Infection					

TERMS OF THIS AUTHORIZATION

1. I understand that CommuniCare Advantage will not condition my treatment, enrollment, or eligibility for health insurance benefits on my signing of this Authorization.
2. I understand that CommuniCare Advantage will release my health information as directed by the terms and conditions of this Authorization. I understand that information once released according to this Authorization is out of CommuniCare Advantage's control and CommuniCare Advantage becomes unable to further safeguard such information or prevent re-disclosure by the Recipient.
3. I understand that I have a right to receive a copy of this Authorization.
4. I understand that I may revoke this Authorization in writing at any time.
5. I desire this Authorization to remain in effect until ___________________ (please specify a date). I understand that if I do not specify a date, this Authorization will remain in effect for two (2) years from the date of signature on this form. (For a minor, this Authorization will expire in two (2) years or the day before the minor's 18th birthday, whichever is earlier.)

I have read and understand the terms of this Authorization and I hereby authorize the release/dislosure of my health information in the manner described above.

______________________________	__________________	____________________________
Signature* (required)	**Date (required)**	**Printed Name (required)**

This Authorization will only be valid if it is signed by the member or other person with legal authority for the member. If you are not the member, please indicate your relationship to the member below.

☐ **Legally authorized representative (e.g., Power of Attorney)**

Form of legal authorization:**

***You must submit a copy of the legal authorization if not already provided.*

SEND COMPLETED FORM TO:	CommuniCare Advantage PO Box 94038 Lubbock, TX 79493 FAX: (855) 969-5871

This **Member Authorization** form is used for a member to authorize [Health Plan Name] to disclose information to an individual or entity.

Note: The Member Authorization form is not necessary for parents of minor children currently enrolled on the same policy to receive information about the minor, unless the information is related to a protected category (see additional restrictions below).

Please read the following instructions prior to completing this form.
Information Authorized to be Released/Disclosed: Please complete this section to identify the information that should be disclosed, and the recipient authorized to receive it.

> **Health information to release/disclose:** You may limit the information by type (for example, demographic information or claims information) or by a certain time period.
>
> **Name of Recipient:** You may authorize either an individual or entity/company to receive your information. The individual/entity must be specifically named.
>
> **Role of Recipient:** For example, parent/guardian, broker, consultant.
>
> **Address of Recipient:** Address of the individual/entity authorized to receive your information.
>
> **Purpose:** The authorization for release of information must be related to a specific issue or event (for example, to solve a claim or benefit issue).

Protected Categories: For individuals age 12 and older, information related to the protected categories will not be disclosed unless specifically authorized by the member. The member may choose to authorize the disclosure of information in none, some, or all the listed categories.

Who should sign the form?
This form must be signed by the member or a person with legal authority for the member (for example, power of attorney or health care proxy). If signed by someone other than the member, a copy of the legal authorization must also be submitted if not already on file.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-855-969-5861 (TTY: 711).

General Notice About Nondiscrimination and Accessibility Requirements

CommuniCare Advantage and its affiliates as noted below comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CommuniCare Advantage does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

CommuniCare Advantage:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact Member Services.

If you believe that CommuniCare Advantage has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by calling 1-855-969-5861, by fax at 1-855-969-5871, or by mailing it to:

CommuniCare Advantage Appeals and Grievances
PO Box 94138
Lubbock, TX 79493

If you need help filing a grievance, Member Services is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue,
SW Room 509F, HHH Building
Washington, D.C. 20201

(800) 368-1019, (800) 537-7697 (TTY)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
CommuniCare Advantage includes CommuniCare Advantage of Ohio, Indiana, and Maryland