Authorization to Release Information

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows the Care Improvement Plus (your health insurance carrier) to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to Care Improvement Plus (contact Member Services for further instructions). Revoking this authorization will not affect any action taken prior to receipt of your written request.

Member Information: (individual whose information will be released) [Please print]

Name: (First, Middle, Last, Title)	**Member ID Number:**	**Date of Birth:** (Month/Day/Year)
Address: (including zip code)	**Telephone Number:** (including area code)	

Recipient: (person or organization that will receive your information) [Please print]

Person's Name or Organization:	**Relationship:**	**Telephone Number:** (including area code)
Address: (including zip code)		**Fax Number:** (if available)
Person's Name or Organization:	**Relationship:**	**Telephone Number:** (including area code)
Address: (including zip code)		**Fax Number:** (if available)
Person's Name or Organization:	**Relationship:**	**Telephone Number:** (including area code)
Address: (including zip code)		**Fax Number:** (if available)

Description of the Information to be Released: (what type of information will be released) [Please print]

☐ **All information related to the provision of and payment for my health care benefits or services.***

☐ **Specific information described below:***

____

Examples: The claim related to my service on (date); Appeal information related to my claim on (date)

***NOTE**: State law may require specific permission to release the information below even if you checked a box above. Indicate your permission for Care Improvement Plus to release any of the following information by initialing all that apply.

Genetic Information ____________ (Initials) **HIV/AIDS** ____________ (Initials)

Substance/Alcohol Abuse ____________ (Initials) **Mental/Behavioral Health** ____________ (Initials)

Expiration: (when this authorization will end) [Please print]

This authorization will expire upon termination of my enrollment with Care Improvement Plus unless I specify another date or event below: ☐ **Date:** ____/____/____(mm/dd/yyyy) **OR** ☐ **Event:** Upon the occurrence of the following event:

____

Examples: Until I revoke this authorization; Resolution of a specific issue

Approval: (You OR your personal representative must sign and date this form in order for it to be complete.)

I understand that this authorization to release information is voluntary and is not a condition of enrollment in Care Improvement Plus, eligibility for benefits, or payment of claims. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws.

Member Signature: By signing below, I authorize the use of my protected health information.

________________________ ________________________

(Signature of Member) (Date)

Personal Representative Information: 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 court-related legal document must be on file at the health plan.

________________________ ____________ (____)__________

(Printed Name of Personal Representative) (Date) (Telephone Number)

________________________ ________________________

(Signature of Personal Representative) (Description of representative's authority)

PLEASE KEEP A COPY OF THIS FORM AND THE INSTRUCTIONS FOR YOUR RECORDS

Instructions for Authorization to Release Information

The enclosed Authorization to Release Information form is required in order to allow your health plan, Care Improvement Plus, to release protected health informat ion to another person or organization. Please review and complete the form. A number of important points are highlighted here. Each section of the form must be completed; missing information will result in delays in processing the authorization.

- ❑ Include your Member Identification Number.
- ❑ List in the “Recipient” section the name of the person or organization to whom you are authorizing your health plan to release information. Be sure to include the recipient’s contact information such as telephone number, fax number or address.
- ❑ Review the “Description of the Information to be Released” section before completing.
  - ✓ You should only check **one** of the three boxes listed.
  - ✓ If someone routinely assists you with your health ca re, for example, husband, wife, son or daughter, you may want to give that person access to all your information. To do this check the second box in this section and initial any/all applicable areas in the “Notes” section.
  - ✓ Check the “Specific Information” box if an individual is assisting you in resolving a particular issue such as an appeal, and initial any/all applicable areas in the “Notes” section.
- ❑ An “Expiration” must be listed. The default expiration date is termination of your enrollment with Care Improvement Plus. You can also allow the authorization to remain in effect until you revoke it in writing, or indicate that the authorization will expire on a specific date or at the conclusion of an event, such as an appeal.
- ❑ You or your personal representative (such as a power of attorney or guardian) must sign the authorization. If a personal representative signs the authorization, a copy of the legal documents showing you have authority to act on the member’s behalf must be submitted with the authorization.

If any of the checked items are wrong, or if you have any questions, please call us at 1-800-204-1002. TTY users should call 711. We are open 7 days a week from 8:00 am to 8:00 pm.

RETURN THIS FORM AS INSTRUCTED BY YOUR HEALTH PLAN