AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This authorization is voluntary and may be used to permit Community Health Choice (Community) to use or disclose an individual's protected health information (PHI).

Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their PHI.

☐ As a member (over 18 years of age) of Community, I am requesting disclosure of PHI to the individual as requested below.

☐ As a parent/guardian of a member (under 18 years of age) of Community, I am requesting disclosure of PHI as requested below, and have included proof of identity and legal rights.

MEMBER FULL NAME

MEMBER ID NUMBER

MEMBER DATE OF BIRTH ___ / ___ / ____

MAILING ADDRESS

CITY

ZIP CODE

DAY PHONE ___ / ___ / ____

OTHER PHONE ___ / ___ / ____

E-MAIL ADDRESS

EFFECTIVE TIME PERIOD: Please choose and complete one.

This authorization is valid for a period of one year from the date signed: Month ___ Day ___ Year ____

This authorization shall only be valid until: Month ___ Day ___ Year ____

RIGHT TO REVOKE:

I understand that I can withdraw my permission at any time by sending Community a letter via mail, email or fax, to the address listed at the end of this document. Your letter must also include the member's full name, member number, address, and phone number.

The authorization will have no effect on actions Community took in good faith before receiving a letter to withdraw authorization.

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

NAME

MAILING ADDRESS

CITY

ZIP CODE

DAY PHONE / /

OTHER PHONE / /

PLEASE SELECT THOSE THAT APPLY:

- ☐ Self
- ☐ Natural or Adoptive Parent
- ☐ Foster Parent
- ☐ Legal Representative – someone with legal authority to act on the member's behalf
- ☐ Legal Guardian
- ☐ Spouse
- ☐ Step-Parent
- ☐ Other _____

If the person signing this authorization is not the member, you must provide a copy of the health care power of attorney, birth certificate or other relevant document that authorizes you to act on the members' behalf, and proof of identity.

WHAT INFORMATION CAN BE DISCLOSED?

- ☐ All Information described below

- ☐ Benefits, Billing, and Claim Information
- ☐ Primary Care Provider Changes
- ☐ Home Address Changes
- ☐ Identification Card Request
- ☐ Premium Payment
- ☐ Name Spelling and other Personal Information

Your initials are required to release the following information:

____ Mental Health Information

____ Drug, Alcohol or Substance Abuse

____ Pregnancy/Family Planning

____ HIV/AIDS

Please Note: There are limitations to the amount of information we are able to share with others in regards to your account. Note to parents: these limitations may not affect the legal rights you have to access your child's information by other means, like contacting your child's primary care physician.

HIPAA STATEMENT:

This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.

Covered entities, as the term is defined by HIPAA and Texas Health and Safety, must obtain a signed authorization from an individual or the individual's legally authorized representative to disclose that individuals Protected Health Information (PHI).

The Authorization provided by use of the form means the organization, entity or person authorized can disclose, communicate, or send named individuals PHI to the organization, entity or person identified on the form, including through use of any electronic means.

I understand that Community does not require that I waive my right to submit a claim to the Secretary of HHS in order to receive treatment, payment, enrollment in a health plan or determine eligibility of benefits.

SIGNATURE AND AUTHORIZATION:

I have read this form in its entirety and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of PHI that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities.

I understand this authorization is completely voluntary. I can refuse to sign it, and I understand that treatment, coverage, enrollment, eligibility and/or other benefits cannot be conditioned upon my willingness to sign this authorization.

Date signed is the effective date of this authorization

SIGNATURE: ____ DATE: __ __ / __ __ / __ __ __ __

Signature of Individual or Individual's Legally Authorized Representative

Printed name of legally Authorized Representatives (if applicable):

A minor individual signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol, or substance abuse, and mental health treatment:

SIGNATURE: ____ DATE: __ __ / __ __ / __ __ __ __

Members: This completed form or letter of withdrawal can be submitted

E-mail: MemberServices@CommunityHealthChoice.org

Fax: 713.295.2293 – Fulfillment Department

Mail: Community Health Choice
Attention: Fulfillment Department
488 Loop Central Dr. Suite 600
Houston, TX 77081