



ROI Form: Authorization for Use or Disclosure of Health Information

NOTE: This form does not authorize health care decision-making authority

1. Member/Patient information

Name: <small>Last Name, First Name, Middle Initial</small>	DOB:	CCA ID:
Address: <small>Street Address, City/State, Zip Code</small>	Phone:	Email Address:

2. Permission to release/disclose Member/Patient health information

I authorize CCA/CCA Primary Care to Disclose Member/Patient health information to **or** Obtain from
 Person/Organization Name: _____ Phone: ____ - ____ - ____ Email: _____
 Street Address: _____ City: _____ State: _____ Zip Code: _____

Description: Full or Partial Record For this time frame: ____ / ____ / ____ To: ____ / ____ / ____ or Indefinite

Purpose (optional) : At the request of the Member/Patient Other: _____

In the form of: Oral/Written and/or Electronic/Paper Copies by: Fax Email Delivery or Pick-up

3. Sensitive Information: You must initial each box below in order for us to release this sensitive information

Abortion		Behavioral Health		HIV	
AIDS/ARC		Genetic Testing		Physical Abuse	
Alcohol & Substance Use		Domestic Violence		Sexually Transmitted Infection	
Reproductive Health					

4. Expiration and Cancellation

Unless otherwise revoked, this AUTHORIZATION is valid for the Member's enrollment term with CCA or as specified:

On this date: ____ / ____ / ____ OR Event: _____

5. SIGN BELOW: The signature below is my own and I am legally authorized to sign this document

Member/Patient or Personal Representative* Signature: _____ **Date:** ____ / ____ / ____

**Print your name, phone number, and email below. Check (✓) the box that shows your legal authority under law to sign this form on the Member/Patient's behalf. Please return this completed form with supporting documentation.*

Print Personal Representative Full Name: _____ **Phone:** ____ - ____ - ____ **Email:** _____

- Attorney Guardian/Conservator Health Care Agent HIPAA Agent/Representative
 Representative of Estate/Executor Power of Attorney Other Advocate

I understand that the health information disclosed pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by law. I have the right to revoke this Authorization in writing at any time by sending written revocation to the address below. I understand that my treatment, enrollment, or eligibility for health insurance benefits does not depend on my signing this Authorization.

Please mail, fax, or email as indicated below. For questions call Member Services at: 866-610-2273

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