commonwealth care alliance

AUTHORIZATION FOR ORAL DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

1. Member Information

Name: *Last Name, First Name, Middle Initial*	**Date of Birth:**	**CCA ID:**
Address: *Street Address, City/State, Zip Code*	**Phone:**	**Email Address:**

2. Permission to Orally Disclose Member Health Information

I authorize CCA to ☐ orally disclose member health information to:

Person/Organization Name: _____ Phone: ____-____-____

Email: _____

Street Address: _____ City: _____ State: _____

Zip Code: _____

Topic of health information to be discussed: _____

☐ For this time frame: ____/____/____ TO: ____/____/____

3. Sensitive Information: You must initial each box below in order for CCA to orally disclose 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 Revocation

Unless otherwise revoked, this AUTHORIZATION is valid for the member's enrollment term with CCA or as specified: ☐ On this date: ____/____/____ OR Event:

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

Member/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'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, payment, enrollment in the health plan or eligibility for benefits does not depend on my signing this Authorization. The entity that seeks this Authorization must provide me with a copy of this signed form.

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

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